

DATE: 11/03/16 @ 0002 Mercy Fitzgerald Hospital PHA \*LIVE\* PAGE 201  
 USER: MT Medication Administration Summary

Patient EFUNNUGA, OLUTOKUNBO Responsible Doctor LITTMAN, MARIO, MD  
 Account Number FA1307223089 Location FI4PVA Unit Number F001250247  
 Age/Sex 37/M Room 411 Registered Date 10/07/16  
 Status DIS IN Bed 02 Discharged Date 11/01/16

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

10/28/16	0831 FICARTEN	Y	1	0.00
(10/28/16) (0900) Dose: 100 MG				
10/29/16	0902 FIHALLAM	Y	1	0.00
(10/29/16) (0900) Dose: 100 MG				
10/30/16	0825 FIBLEILA	Y	1	0.00
(10/30/16) (0900) Dose: 100 MG				
10/31/16	0857 FIMOSLEK	Y	1	0.00
(10/31/16) (0900) Dose: 100 MG				
11/01/16	1036 FIHALLAM	Y	1	0.00
(11/01/16) (0900) Dose: 100 MG				

Admin Totals 7 0

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Patient EFUNNUGA, OLUTOKUNBO Responsible Doctor LITTMAN, MARIO, MD  
 Account Number FA1307223089 Location FI4PVA Unit Number F001250247  
 Age/Sex 37/M Room 411 Registered Date 10/07/16  
 Status DIS IN Bed 02 Discharged Date 11/01/16

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

MULT-136 - MULTIVITAMINS TABLET

Dose 1 TAB (1 TABLET)  
 Admin Route PO  
 Start Date 10/26/16-0900 Stop Date None DC Date 11/01/16-2054  
 Ordering Doctor MANN, RUPINDER K MD  
 Total Dispensed 7 Total Costs \$0.21 Total Charges \$7.35  
 Rx Number 001894443

Discontinue Comments DC'd by Discharge

History

10/26/16 0715 - POM ORDER by COMANNR  
 10/26/16 0717 - VERIFIED by FIANDERC  
 10/26/16 0953 - DEBIT by DGILMAN  
 ITEMS: 1 DOSES: 1  
 10/27/16 0816 - DEBIT by MMAXWELL  
 ITEMS: 1 DOSES: 1  
 10/28/16 0828 - DEBIT by NCARTER  
 ITEMS: 1 DOSES: 1  
 10/29/16 0840 - DEBIT by MHALLAMY  
 ITEMS: 1 DOSES: 1  
 10/30/16 0731 - DEBIT by ABLEILER  
 ITEMS: 1 DOSES: 1  
 10/31/16 0845 - DEBIT by KMOSLEY  
 ITEMS: 1 DOSES: 1  
 11/01/16 1024 - DEBIT by MHALLAMY  
 ITEMS: 1 DOSES: 1  
 11/01/16 2055 - DISCONTINUE by DISCHARGE Eff: 11/01/16 2054  
 FROM:  
 DC COMMENTS:  
 TO:  
 DC COMMENTS:  
 DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/26/16	1001	FIGILMAD	Y			1	0.00
(10/26/16) (0900) Dose: 1 TAB							
10/27/16	0826	FIMAXWEM	Y			1	0.00
(10/27/16) (0900) Dose: 1 TAB							
10/28/16	0831	FICARTEN	Y			1	0.00
(10/28/16) (0900) Dose: 1 TAB							
10/29/16	0901	FIHALLAM	Y			1	0.00
(10/29/16) (0900) Dose: 1 TAB							

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Patient **EFUNNUGA, OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

**EFUNNUGA, OLUTOKUNBO**      **FA1307223089**      **(Continued)**

10/30/16	0826 FIBLEILA	Y	1	0.00
(10/30/16) (0900) Dose: 1 TAB				
10/31/16	0856 FIMOSLEK	Y	1	0.00
(10/31/16) (0900) Dose: 1 TAB				
11/01/16	1035 FIHALLAM	Y	1	0.00
(11/01/16) (0900) Dose: 1 TAB				

<b>Admin Totals</b>			<u>7</u>	<u>0</u>
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Patient **EFUNNUGA, OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

**NYST100SM - Nystatin 500 MU/5 ML SUSPENSION**

Dose **500 MU (5 ML)**  
 Dose Instruction **SWISH AND SWALLOW**  
 Admin Route **PO**  
 Start Date **10/26/16-1700**      Stop Date **None**      DC Date **10/27/16-1348**  
 Ordering Doctor **MANN, RUPINDER K MD**  
 Clinical Indication **SKIN & SOFT TISSUE**  
 Total Dispensed **3**      Total Costs **\$2.79**      Total Charges **\$5.85**  
 Rx Number **001895070**

**History**

10/26/16 1602 - POM COPY AND EDIT      by COMANNR  
 FROM: Rx #001889974  
 10/26/16 1613 - VERIFIED      by FILINC  
 10/26/16 1806 - DEBIT      by TNOGA  
 ITEMS: 1      DOSES: 1  
 10/26/16 2121 - DEBIT      by MMCGILL  
 ITEMS: 1      DOSES: 1  
 10/27/16 0819 - DEBIT      by MMAXWELL  
 ITEMS: 1      DOSES: 1  
 10/27/16 1350 - DISCONTINUE      by COGILBEM      Eff: 10/27/16 1348  
 EDIT DOCTOR: GILBERT, MARK, MD  
 EDIT SOURCE: Provider Source

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/26/16	1746	FINOGAT	Y			1	0.00
(10/26/16) (1700) Dose: 500 MU							
10/26/16	1848	FINOGAT	Y			1	0.00
(10/26/16) (2100) Dose: 500 MU							
10/27/16	0826	FIMAXWEM	Y			1	0.00
(10/27/16) (0900) Dose: 500 MU							
10/27/16	1300	FISTASKJ	N		DC		
(10/27/16) (1300) Dose: 0 MU							
<b>Admin Totals</b>						<b>3</b>	<b>0</b>

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Patient **EFUNNUGA, OLUTOKUNBO** Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089** Location **FI4PVA** Unit Number **F001250247**  
 Age/Sex **37/M** Room **411** Registered Date **10/07/16**  
 Status **DIS IN** Bed **02** Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

ACET325T10 - Acetaminophen 325 MG TABLET (TYLENOL)

Dose 650 MG (2 TABLETS)  
 Admin Route PO  
 Frequency Q4H (PRN) PAR= PRN REASON: FEVER OR PAIN 1-3  
 Start Date 10/27/16-0830 Stop Date None DC Date 11/01/16-2054  
 Ordering Doctor IRIARTE OPORTO, BLANCA E MD  
 Total Dispensed 22 Total Costs \$0.33 Total Charges \$23.10  
 Rx Number 001895580

Discontinue Comments DC'd by Discharge

**History**

10/27/16 0822 - POM ORDER	by COIRIATB	
10/27/16 0827 - VERIFIED	by FIANDERC	
10/27/16 0845 - DEBIT	by MMAXWELL	
ITEMS: 2 DOSES: 1		
10/29/16 0437 - DEBIT	by JAEKIM	
ITEMS: 2 DOSES: 1		
10/29/16 1709 - DEBIT	by MHALLAMY	
ITEMS: 2 DOSES: 1		
10/30/16 0613 - DEBIT	by KSKANE	
ITEMS: 2 DOSES: 1		
10/30/16 1531 - DEBIT	by ABLEILER	
ITEMS: 2 DOSES: 1		
10/30/16 1904 - DEBIT	by ABLEILER	
ITEMS: 2 DOSES: 1		
10/31/16 0026 - DEBIT	by DTAGOE	
ITEMS: 2 DOSES: 1		
10/31/16 0628 - DEBIT	by DTAGOE	
ITEMS: 2 DOSES: 1		
10/31/16 1901 - DEBIT	by KMOSLEY	
ITEMS: 2 DOSES: 1		
11/01/16 1324 - DEBIT	by MHALLAMY	
ITEMS: 2 DOSES: 1		
11/01/16 1729 - DEBIT	by MHALLAMY	
ITEMS: 2 DOSES: 1		
11/01/16 2055 - DISCONTINUE	by DISCHARGE	Eff: 11/01/16 2054
FROM:		
DC COMMENTS:		
TO:		
DC COMMENTS:		
DC'd by Discharge		

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/27/16	0851	FIMAXWEM	Y			2	
Dose: 650 MG							

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Patient EFUNNUGA, OLUTOKUNBO Responsible Doctor LITTMAN, MARIO, MD  
 Account Number FA1307223089 Location FI4PVA Unit Number F001250247  
 Age/Sex 37/M Room 411 Registered Date 10/07/16  
 Status DIS IN Bed 02 Discharged Date 11/01/16

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

10/29/16	0444 FIKIMJ	Y	2
	Dose: 650 MG		
10/29/16	1709 FIHALLAM	Y	2
	Dose: 650 MG		
10/29/16	1821 FIHALLAM	N	
	Dose: 650 MG		
10/30/16	0615 FISKANEK	Y	2
	Dose: 650 MG		
10/30/16	1531 FIBLEILA	Y	2
	Dose: 650 MG		
10/30/16	1906 FIBLEILA	Y	2
	Dose: 650 MG		
10/31/16	0032 FITAGOED	Y	2
	Dose: 650 MG		
10/31/16	0648 FITAGOED	Y	2
	Dose: 650 MG		
10/31/16	1902 FIMOSLEK	Y	2
	Dose: 650 MG		
11/01/16	1331 FIHALLAM	Y	2
	Dose: 650 MG		
11/01/16	1735 FIHALLAM	Y	2
	Dose: 650 MG		

Admin Totals

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Patient EFUNNUGA OLUTOKUNBO Responsible Doctor LITTMAN, MARIO, MD  
 Account Number FA1307223089 Location FI4PVA Unit Number F001250247  
 Age/Sex 37/M Room 411 Registered Date 10/07/16  
 Status DIS IN Bed 02 Discharged Date 11/01/16

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

CARV3.12 - CARVEDILOL 3.125 MG TABLET

Dose 3.125 MG (1 TABLET)  
 Dose Instruction Hold for SBP <100, HR<60  
 Admin Route PO  
 Start Date 10/27/16-2100 Stop Date 10/27/16 2100 DC Date 10/27/16-2100  
 Ordering Doctor JILANI, ABUBAKER K MD  
 Total Dispensed 0 Total Costs \$ Total Charges \$  
 Rx Number 001895875

#### History

10/27/16 1319 - POM ORDER by COJILANA  
 10/27/16 1320 - EDIT by COJILANA  
 EDIT DOCTOR: JILANI, ABUBAKER K MD  
 EDIT SOURCE: Provider Source  
 FROM:  
 START: 10/27/16-2100 STOP: None SOFT STOP:  
 TO:  
 START: 10/27/16-2100 STOP: 10/27/16-2100 SOFT STOP:  
 10/27/16 1320 - VERIFIED by SYSTEM  
 Verified in order to DC  
 10/27/16 1320 - DISCONTINUE by COJILANA Eff: 10/27/16 2100  
 EDIT DOCTOR: JILANI, ABUBAKER K MD  
 EDIT SOURCE: Provider Source

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Account Number	FA1307223089	Location	FI4PVA
Age/Sex	37/M	Room	411
Status	DIS IN	Bed	02
		Unit Number	F001250247
		Registered Date	10/07/16
		Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

METO25TA5 - METOPROLOL TARTRATE 25 MG TABLET (LOPRESSOR)

Dose	6.25 MG (0.25 TABLETS)
Dose Instruction	Hold for SBP<100, HR<60
Admin Route	PO
Start Date	10/27/16-2100
Stop Date	None
DC Date	11/01/16-2054
Ordering Doctor	JILANI, ABUBAKER K MD
Total Dispensed	10
Total Costs	\$0.50
Total Charges	\$10.50
Rx Number	001895879

Discontinue Comments DC'd by Discharge

## History

10/27/16 1320 - POM ORDER	by COJILANA
10/27/16 1325 - VERIFIED	by FILINC
10/27/16 2145 - DEBIT	by JDESALVO
ITEMS: 1 DOSES: 1	
10/28/16 0827 - DEBIT	by NCARTER
ITEMS: 1 DOSES: 1	
10/28/16 2118 - DEBIT	by JAEKIM
ITEMS: 1 DOSES: 1	
10/29/16 0841 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
10/29/16 2055 - DEBIT	by KSKANE
ITEMS: 1 DOSES: 1	
10/30/16 0731 - DEBIT	by ABLEILER
ITEMS: 1 DOSES: 1	
10/30/16 2015 - DEBIT	by DTAGOE
ITEMS: 1 DOSES: 1	
10/31/16 0845 - DEBIT	by KMOSLEY
ITEMS: 1 DOSES: 1	
10/31/16 2039 - DEBIT	by DTAGOE
ITEMS: 1 DOSES: 1	
11/01/16 1024 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
11/01/16 2055 - DISCONTINUE	by DISCHARGE
FROM:	Eff: 11/01/16 2054
DC COMMENTS:	
TO:	
DC COMMENTS:	
DC'd by Discharge	

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/27/16	2100	FIDESALJ	N		REFUSED		
(10/27/16) (2100) Dose: 0 MG							
10/28/16	0831	FICARTEN	Y			1	0.00
(10/28/16) (0900) Dose: 6.25 MG							



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Patient **EFUNNUGA OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

10/28/16	2122 FIKIMJ	Y	1	0.00
(10/28/16) (2100) Dose: 6.25 MG				
10/29/16	0902 FIHALLAM	Y	1	0.00
(10/29/16) (0900) Dose: 6.25 MG				
10/29/16	2208 FISKANEK	Y	1	0.00
(10/29/16) (2100) Dose: 6.25 MG				
10/30/16	0826 FIBLEILA	Y	1	0.00
(10/30/16) (0900) Dose: 6.25 MG				
10/30/16	2053 FITAGOED	Y	1	0.00
(10/30/16) (2100) Dose: 6.25 MG				
10/31/16	0856 FIMOSLEK	Y	1	0.00
(10/31/16) (0900) Dose: 6.25 MG				
10/31/16	2106 FITAGOED	Y	1	0.00
(10/31/16) (2100) Dose: 6.25 MG				
11/01/16	1036 FIHALLAM	Y	1	0.00
(11/01/16) (0900) Dose: 6.25 MG				

Admin Totals

9 0

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Patient **EFUNNUGA, OLUTOKUNBO** Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089** Location **FI4PVA** Unit Number **F001250247**  
 Age/Sex **37/M** Room **411** Registered Date **10/07/16**  
 Status **DIS IN** Bed **02** Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

CLOT10TR2 - Clotrimazole 10 MG TROCHE

Dose 10 MG (1 TROCHE)  
 Admin Route MM  
 Start Date 10/27/16-1600 Stop Date None DC Date 11/01/16-2054  
 Ordering Doctor GILBERT, MARK, MD  
 Clinical Indication EARS, NOSE & THROAT  
 Total Dispensed 22 Total Costs \$12.10 Total Charges \$35.20  
 Rx Number 001895920

Discontinue Comments DC'd by Discharge

#### History

10/27/16 1350 - POM ORDER	by COGILBEM
10/27/16 1357 - VERIFIED	by FILINC
10/27/16 1559 - DEBIT	by JSTASKY
ITEMS: 1 DOSES: 1	
10/28/16 0050 - DEBIT	by AGARDOSE
ITEMS: 1 DOSES: 1	
10/28/16 0828 - DEBIT	by NCARTER
ITEMS: 1 DOSES: 1	
10/28/16 2119 - DEBIT	by JAEKIM
ITEMS: 1 DOSES: 1	
10/29/16 0841 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
10/29/16 1315 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
10/29/16 1615 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
10/29/16 2055 - DEBIT	by KSKANE
ITEMS: 1 DOSES: 1	
10/30/16 0133 - DEBIT	by KSKANE
ITEMS: 1 DOSES: 1	
10/30/16 0732 - DEBIT	by ABLEILER
ITEMS: 1 DOSES: 1	
10/30/16 1132 - DEBIT	by ABLEILER
ITEMS: 1 DOSES: 1	
10/30/16 1525 - DEBIT	by ABLEILER
ITEMS: 1 DOSES: 1	
10/30/16 2015 - DEBIT	by DTAGOE
ITEMS: 1 DOSES: 1	
10/31/16 0036 - DEBIT	by DTAGOE
ITEMS: 1 DOSES: 1	
10/31/16 0846 - DEBIT	by KMOSLEY
ITEMS: 1 DOSES: 1	
10/31/16 1140 - DEBIT	by KMOSLEY
ITEMS: 1 DOSES: 1	
10/31/16 1607 - DEBIT	by KMOSLEY

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Account Number	FA1307223089	Location	FI4PVA
Unit Number	F001250247		
Age/Sex	37/M	Room	411
Status	DIS IN	Bed	02
		Registered Date	10/07/16
		Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

ITEMS: 1      DOSES: 1  
10/31/16 2039 - DEBIT      by DTAGOE  
ITEMS: 1      DOSES: 1  
11/01/16 0010 - DEBIT      by DTAGOE  
ITEMS: 1      DOSES: 1  
11/01/16 1025 - DEBIT      by MHALLAMY  
ITEMS: 1      DOSES: 1  
11/01/16 1309 - DEBIT      by MHALLAMY  
ITEMS: 1      DOSES: 1  
11/01/16 1710 - DEBIT      by MHALLAMY  
ITEMS: 1      DOSES: 1  
11/01/16 2055 - DISCONTINUE      by DISCHARGE      Eff: 11/01/16 2054  
FROM:  
DC COMMENTS:  
TO:  
DC COMMENTS:  
DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/27/16	1600	FISTASKJ	N		OTHER		
(10/27/16) (1600) Dose: 0 MG							
10/27/16	2000	FIDESALJ	N		REFUSED		
(10/27/16) (2000) Dose: 0 MG							
10/28/16	0049	FIGARDOA	Y			1	0.00
(10/28/16) (0000) Dose: 10 MG							
10/28/16	0831	FICARTEN	Y			1	0.00
(10/28/16) (0800) Dose: 10 MG							
10/28/16	1200	FICARTEN	N		REFUSED		
(10/28/16) (1200) Dose: 0 MG							
10/28/16	1600	FICARTEN	N		REFUSED		
(10/28/16) (1600) Dose: 0 MG							
10/28/16	2122	FIKIMJ	Y			1	0.00
(10/28/16) (2000) Dose: 10 MG							
10/29/16	0000	FIKIMJ	N		REFUSED		
(10/29/16) (0000) Dose: 0 MG							
10/29/16	0901	FIHALLAM	Y			1	0.00
(10/29/16) (0800) Dose: 10 MG							
10/29/16	1327	FIHALLAM	Y			1	0.00
(10/29/16) (1200) Dose: 10 MG							
10/29/16	1616	FIHALLAM	Y			1	0.00

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Patient EFUNNUGA, OLUTOKUNBO Responsible Doctor LITTMAN, MARIO, MD  
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 Age/Sex 37/M Room 411 Registered Date 10/07/16  
 Status DIS IN Bed 02 Discharged Date 11/01/16

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

(10/29/16) (1600) Dose: 10 MG				
10/29/16	2208 FISKANEK	Y	1	0.00
(10/29/16) (2000) Dose: 10 MG				
10/30/16	0134 FISKANEK	Y	1	0.00
(10/30/16) (0000) Dose: 10 MG				
10/30/16	0738 FIBLEILA	Y	1	0.00
(10/30/16) (0800) Dose: 10 MG				
10/30/16	1131 FIBLEILA	Y	1	0.00
(10/30/16) (1200) Dose: 10 MG				
10/30/16	1531 FIBLEILA	Y	1	0.00
(10/30/16) (1600) Dose: 10 MG				
10/30/16	2052 FITAGOED	Y	1	0.00
(10/30/16) (2000) Dose: 10 MG				
10/31/16	0036 FITAGOED	Y	1	0.00
(10/31/16) (0000) Dose: 10 MG				
10/31/16	0857 FIMOSLEK	Y	1	0.00
(10/31/16) (0800) Dose: 10 MG				
10/31/16	1140 FIMOSLEK	Y	1	0.00
(10/31/16) (1200) Dose: 10 MG				
10/31/16	1606 FIMOSLEK	Y	1	0.00
(10/31/16) (1600) Dose: 10 MG				
10/31/16	2106 FITAGOED	Y	1	0.00
(10/31/16) (2000) Dose: 10 MG				
11/01/16	0010 FITAGOED	Y	1	0.00
(11/01/16) (0000) Dose: 10 MG				
11/01/16	1036 FIHALLAM	Y	1	0.00
(11/01/16) (0800) Dose: 10 MG				
11/01/16	1331 FIHALLAM	Y	1	0.00
(11/01/16) (1200) Dose: 10 MG				
11/01/16	1710 FIHALLAM	Y	1	0.00
(11/01/16) (1600) Dose: 10 MG				

Admin Totals

21 0

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Patient **EFUNNUGA OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

ALTE2VIA2 - ALTEPLASE 2 MG VIAL

Dose **2 MG (1 VIAL)**  
 Admin Route **IV**  
 Start Date **10/28/16-1130**      Stop Date **10/28/16 1131**      DC Date **10/28/16-1131**  
 Ordering Doctor **JADHAV, GAURAV P MD**  
 Total Dispensed **0**      Total Costs \$      Total Charges \$  
 Rx Number **001896702**

Discontinue Comments Reached Stop Date

**History**

10/28/16 1124 - POM ORDER      by COJADHAG  
 10/28/16 1132 - VERIFIED      by FIRECEVM  
 10/28/16 1132 - DISCONTINUE      by PHABKGJOB      Eff: 10/28/16 1131

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

Reached Stop Date

Admin Date	Time	User	Given	Baq	Reason Code	Items	Charge
10/28/16	1130	FIKIMJ	N		MU		
(10/28/16) (1130) Dose: 0 MG							

Admin Totals

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 USER: MT Medication Administration Summary

Patient **EFUNNUGA, OLUTOKUNBO** Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089** Location **FI4PVA** Unit Number **F001250247**  
 Age/Sex **37/M** Room **411** Registered Date **10/07/16**  
 Status **DIS IN** Bed **02** Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

CLON1TAB25 - clonazepam 1 MG TABLET

Dose 1 MG (1 TABLET)  
 Admin Route PO  
 Frequency Q12H (PRN) PAR= PRN REASON: A/A - AGITATION/ANXIETY  
 Start Date 10/28/16-2100 Stop Date None DC Date 11/01/16-0611  
 Ordering Doctor JADHAV, GAURAV P MD  
 Total Dispensed 4 Total Costs \$0.20 Total Charges \$12.40  
 Rx Number 001896954

#### History

10/28/16 1558 - POM COPY AND EDIT by COJADHAG  
 FROM: Rx #001887372  
 Result of Frequency/Schedule Edit  
 Ordering Doctor: JADHAV, GAURAV P MD  
 Last Scheduled Administration Time: 10/28/16 - 0900  
 Last Actual Administration Time: 10/28/16 - 0830  
 Old Freq/Sch: BID (SCH)  
 New Freq/Sch: Q12 (PRN)  
 Old Order Stop: 10/28/16 - 1556  
 New Order Start: 10/28/16 - 2100  
 New Order Stop:  
 10/28/16 1605 - EDIT by FIANDERC  
 EDIT DOCTOR: JADHAV, GAURAV P MD  
 FROM:  
 SIG: Q12  
 TO:  
 SIG: Q12H  
 10/28/16 1605 - VERIFIED by FIANDERC  
 10/28/16 2119 - DEBIT by JAEKIM  
 ITEMS: 1 DOSES: 1  
 10/30/16 1127 - DEBIT by ABLEILER  
 ITEMS: 1 DOSES: 1  
 10/31/16 0907 - DEBIT by KMOSLEY  
 ITEMS: 1 DOSES: 1  
 10/31/16 2112 - DEBIT by DTAGOE  
 ITEMS: 1 DOSES: 1  
 11/01/16 0612 - DISCONTINUE by COHAMIDS Eff: 11/01/16 0611  
 EDIT DOCTOR: HAMID, SAMMY, MD  
 EDIT SOURCE: Provider Source

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/28/16	2121	FIKIMJ	Y			1	
		Dose: 1 MG					
10/30/16	1131	FIBLEILA	Y			1	
		Dose: 1 MG					

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 USER: MT      Medication Administration Summary

Patient **EFUNNUGA, OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

10/31/16      0906 FIMOSLEK      Y      1  
                  Dose: 1 MG  
 10/31/16      2114 FITAGOED      Y      1  
                  Dose: 1 MG

Admin Totals      4

HYDR1DIS2 - HYDROmorphone HCL (DILAUDID) 1 MG/ML

Dose      1 MG (1 ML)  
 Admin Route IV  
 Frequency Q3H (PRN) PAR= PRN REASON: pain 7-10  
 Start Date 10/28/16-1745      Stop Date None      DC Date 10/29/16-1011  
 Ordering Doctor JADHAV, GAURAV P MD  
 Total Dispensed 0      Total Costs \$      Total Charges \$  
 Rx Number 001896956

#### History

10/28/16 1555 - POM COPY AND EDIT      by COJADHAG  
 FROM: Rx #001893023  
 10/28/16 1605 - EDIT      by FIANDERC  
 FROM:  
 DUPLICATE COMMENT:  
 TO:  
 DUPLICATE COMMENT: RPH  
 10/28/16 1605 - EDIT      by FIANDERC  
 EDIT DOCTOR: JADHAV, GAURAV P MD  
 FROM:  
 MED: HYDR2DIS5 - HYDROmorphone HCL/Pf  
 RX ID: HYDROmorphone HCL 2 MG/ML DISP.SYRIN  
 CHARGE: \$9.50  
 RX COMMENTS:  
 Order filed UNV:  
 Allergies/Duplicates/Interactions differ from order entry  
 TO:  
 MED: HYDR1DIS2 - HYDROmorphone HCL/Pf  
 RX ID: HYDROmorphone HCL (DILAUDID) 1 MG/ML  
 CHARGE: \$9.25  
 DUPLICATE COMMENT: RPH  
 RX COMMENTS:  
 10/28/16 1606 - VERIFIED      by FIANDERC  
 10/29/16 1012 - DISCONTINUE      by COSHETHV      Eff: 10/29/16 1011  
 EDIT DOCTOR: SHETH, VISHAD M MD  
 EDIT SOURCE: Provider Source



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USER: MT		Medication Administration Summary			

Patient	EFUNNUGA, OLUTOKUNBO		Responsible Doctor LITTMAN, MARIO, MD		
Account Number	FA1307223089	Location	FI4PVA	Unit Number	F001250247
Age/Sex	37/M	Room	411	Registered Date	10/07/16
Status	DIS IN	Bed	02	Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO	FA1307223089	(Continued)
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HYDR5DIS2 - HYDROmorphone HCl 0.5 MG/0.5 ML DISP.SYRIN

Dose 0.5 MG (0.5 ML)  
Admin Route IV  
Frequency Q3H (PRN) PAR= PRN REASON: pain 4-6  
Start Date 10/28/16-1745 Stop Date None DC Date 10/29/16-1011  
Ordering Doctor JADHAV, GAURAV P MD  
Total Dispensed 0 Total Costs \$ Total Charges \$  
Rx Number 001896957

History

10/28/16 1555 - POM COPY AND EDIT by COJADHAG  
FROM: Rx #001893022

10/28/16 1606 - EDIT by FIANDERC  
FROM:  
DUPLICATE COMMENT:  
TO:  
DUPLICATE COMMENT: RPH

10/28/16 1606 - EDIT by FIANDERC  
EDIT DOCTOR: JADHAV, GAURAV P MD  
FROM:  
MED: HYDR1DIS2 - HYDROmorphone HCl/Pf  
RX ID: HYDROmorphone HCL (DILAUDID) 1 MG/ML  
CHARGE: \$9.25  
RX COMMENTS:  
Order filed UNV:  
Allergies/Duplicates/Interactions differ from order entry

TO:  
MED: HYDR5DIS2 - HYDROmorphone HCl/Pf  
RX ID: HYDROmorphone HCl 0.5 MG/0.5 ML DISP.SYRIN  
CHARGE: \$14.00  
DUPLICATE COMMENT: RPH  
RX COMMENTS:

10/28/16 1606 - VERIFIED by FIANDERC  
10/29/16 1012 - DISCONTINUE by COSHETHV Eff: 10/29/16 1011  
EDIT DOCTOR: SHETH, VISHAD M MD  
EDIT SOURCE: Provider Source



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 USER: MT      Medication Administration Summary

Patient **EFUNNUGA, OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

INSU100V42 - INSULIN REGULAR, HUMAN 300 UNIT/3 ML VIAL

Dose Instruction      SS LOW DOSE  
 LOW INTENSITY SCALE:  
 Blood Glucose      Coverage insulin  
 <80mg/dL      Notify House Officer and see below  
 80 - 149      Continue Current regimen  
 150 - 199      2 units  
 200 - 249      3 units  
 250 - 299      4 units  
 300 - 349      5 units  
 350 - 400      6 units  
 Over 400      Call House Officer

Notify House Officer for:

A)Accu-checks <80mg/dL or >400mg/dL for evaluation and  
 adjument of regimen.

B)Change in dietary order (ex:NPO/tube feeding on hold,  
 nausea/vomiting, <1/2 of meal eaten, etc.)

C)BG<70mg/dL:

a.If pt can take by mouth give 15gm of fast acting  
 carbohydrate(4oz fruit juice/non-diet soda OR 4 glucose  
 tabs OR 8oz non-fat milk)

b.If pt cannot receive oral carbohydrates, give 50%  
 dextrose - 25ml (1/2 amp) x 1

c.Check accu-check every 20min until>70mg/dL.

Repeat above treatment (a. or b.) if <70mg/dL

D)For ccu-check reading <40 or >450mg/dL, draw and send a  
 STAT serum glucose

Admin Route SUBQ

Start Date 10/29/16-0745      Stop Date None

DC Date 10/29/16-1010

Ordering Doctor MANZOOR,HOORIA MD

Total Dispensed 0      Total Costs \$

Total Charges \$

Rx Number 001897251

#### History

10/29/16 0104 - POM COPY AND EDIT      by COMANZH

FROM: Rx #001879318

Result of Frequency/Schedule Edit

Ordering Doctor: MANZOOR,HOORIA MD

Last Scheduled Administration Time: 10/28/16 - 2300

Last Actual Administration Time: 10/28/16 - 2115 (Not Given)

Old Freq/Sch: Q6 (SCH)

New Freq/Sch: ACHS (SCH)

Old Order Stop: 10/29/16 - 0103

New Order Start: 10/29/16 - 0745

New Order Stop:

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 USER: MT      Medication Administration Summary

Patient **EFUNNUGA, OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

10/29/16 0124 - VERIFIED      by FISACKSM  
 10/29/16 1011 - DISCONTINUE      by COSHETHV      Eff: 10/29/16 1010  
 EDIT DOCTOR: SHETH, VISHAD M MD  
 EDIT SOURCE: Provider Source

<u>Admin Date</u>	<u>Time</u>	<u>User</u>	<u>Given</u>	<u>Bag</u>	<u>Reason Code</u>	<u>Items</u>	<u>Charge</u>
10/29/16	0745	FIHALLAM	N		GLUCOSE		
(10/29/16) (0745) Dose: 0 UNIT							

Admin Totals

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 USER: MT Medication Administration Summary

Patient **EFUNNUGA OLUTOKUNBO** Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089** Location **FI4PVA** Unit Number **F001250247**  
 Age/Sex **37/M** Room **411** Registered Date **10/07/16**  
 Status **DIS IN** Bed **02** Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

INSU100V - INSULIN LISPRO 100 UNITS/ML (1 ML)

Dose Instruction SS LOW DOSE  
 LOW INTENSITY SCALE:  
 Blood Glucose Coverage insulin  
 <80mg/dL Notify House Officer and see below  
 80 - 149 Continue Current regimen  
 150 - 199 2 units  
 200 - 249 3 units  
 250 - 299 4 units  
 300 - 349 5 units  
 350 - 400 6 units  
 Over 400 Call House Officer

Notify House Officer for:

A)Accu-checks <80mg/dL or >400mg/dL for evaluation and  
 adjument of regimen.

B)Change in dietary order (ex:NPO/tube feeding on hold,  
 nausea/vomiting, <1/2 of meal eaten, etc.)

C)BG<70mg/dL:

a.If pt can take by mouth give 15gm of fast acting  
 carbohydrate(4oz fruit juice/non-diet soda OR 4 glucose  
 tabs OR 8oz non-fat milk)

b.If pt cannot receive oral carbohydrates, give 50%  
 dextrose - 25ml (1/2 amp) x 1

c.Check accu-check every 20min until>70mg/dL.

Repeat above treatment (a. or b.) if <70mg/dL

D)For ccu-check reading <40 or >450mg/dL, draw and send a  
 STAT serum glucose

Admin Route SUBQ

Start Date 10/29/16-1100 Stop Date None

DC Date 11/01/16-2054

Ordering Doctor SHETH,VISHAD M MD

Total Dispensed 0

Total Costs \$

Total Charges \$

Rx Number 001897451

Discontinue Comments DC'd by Discharge

#### History

10/29/16 1011 - POM ORDER

by COSHETHV

10/29/16 1012 - VERIFIED

by FILINC

11/01/16 2055 - DISCONTINUE

by DISCHARGE

Eff: 11/01/16 2054

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

DC'd by Discharge

Admin Date Time User Given Bag Reason Code Items Charge

DATE: 11/03/16 @ 0002  
USER: MT

Mercy Fitzgerald Hospital PHA \*LIVE\*  
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Patient	EFUNNUGA OLUTOKUNBO		Responsible Doctor	LITTMAN, MARIO, MD	
Account Number	FA1307223089	Location	FI4PVA	Unit Number	F001250247
Age/Sex	37/M	Room	411	Registered Date	10/07/16
Status	DIS IN	Bed	02	Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

10/29/16	1100 FIHALLAM	N	GLUCOSE
(10/29/16) (1100) Dose: 0 UNITS			
10/29/16	1630 FIHALLAM	N	GLUCOSE
(10/29/16) (1630) Dose: 0 UNITS			
10/29/16	2100 FISKANEK	N	GLUCOSE
(10/29/16) (2100) Dose: 0 UNITS			
10/30/16	0745 FIBLEILA	N	GLUCOSE
(10/30/16) (0745) Dose: 0 UNITS			
10/30/16	1100 FIBLEILA	N	GLUCOSE
(10/30/16) (1100) Dose: 0 UNITS			
10/30/16	1630 FIBLEILA	N	GLUCOSE
(10/30/16) (1630) Dose: 0 UNITS			
10/30/16	2100 FITAGOED	N	GLUCOSE
(10/30/16) (2100) Dose: 0 UNITS			
10/31/16	0745 FIMOSLEK	N	GLUCOSE
(10/31/16) (0745) Dose: 0 UNITS			
10/31/16	1100 FIMOSLEK	N	GLUCOSE
(10/31/16) (1100) Dose: 0 UNITS			
10/31/16	1630 FIMOSLEK	N	GLUCOSE
(10/31/16) (1630) Dose: 0 UNITS			
10/31/16	2100 FITAGOED	N	GLUCOSE
(10/31/16) (2100) Dose: 0 UNITS			
11/01/16	0745 FIHALLAM	N	GLUCOSE
(11/01/16) (0745) Dose: 0 UNITS			
11/01/16	1100 FIHALLAM	N	GLUCOSE
(11/01/16) (1100) Dose: 0 UNITS			
11/01/16	1630 FIHALLAM	N	GLUCOSE
(11/01/16) (1630) Dose: 0 UNITS			

Admin Totals

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Patient	EFUNNUGA, OLUTOKUNBO		Responsible Doctor	LITTMAN, MARIO, MD	
Account Number	FA1307223089	Location	FI4PVA	Unit Number	F001250247
Age/Sex	37/M	Room	411	Registered Date	10/07/16
Status	DIS IN	Bed	02	Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

TRAM50TA27 - traMADol HCl 50 MG TABLET

Dose 50 MG (1 TABLET)  
Admin Route PO  
Frequency Q4H (PRN) PAR= PRN REASON: SEVERE - SEVERE PAIN  
Start Date 10/29/16-1730 Stop Date None DC Date 11/01/16-2054  
Ordering Doctor JADHAV, GAURAV P MD  
Total Dispensed 9 Total Costs \$0.63 Total Charges \$27.90  
Rx Number 001897704

Discontinue Comments DC'd by Discharge

#### History

10/29/16 1729 - POM ORDER	by COJADHAG
10/29/16 1730 - EDIT	by FILINC
FROM:	
INTERACTION COMMENT:	
TO:	
INTERACTION COMMENT: RPH	
10/29/16 1730 - VERIFIED	by FILINC
10/29/16 1752 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
10/29/16 2213 - DEBIT	by KSKANE
ITEMS: 1 DOSES: 1	
10/30/16 0208 - DEBIT	by KSKANE
ITEMS: 1 DOSES: 1	
10/30/16 1525 - DEBIT	by ABLEILER
ITEMS: 1 DOSES: 1	
10/30/16 1531 - CREDIT	by ABLEILER
ITEMS: 1 DOSES: 1	
10/31/16 0350 - DEBIT	by DTAGOE
ITEMS: 1 DOSES: 1	
10/31/16 1140 - DEBIT	by KMOSLEY
ITEMS: 1 DOSES: 1	
10/31/16 1556 - DEBIT	by KMOSLEY
ITEMS: 1 DOSES: 1	
11/01/16 0221 - DEBIT	by DTAGOE
ITEMS: 1 DOSES: 1	
11/01/16 1026 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
11/01/16 1731 - DEBIT	by MHALLAMY
ITEMS: 1 DOSES: 1	
11/01/16 2055 - DISCONTINUE	by DISCHARGE Eff: 11/01/16 2054
FROM:	
DC COMMENTS:	
TO:	
DC COMMENTS:	
DC'd by Discharge	

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Patient	EFUNNUGA OLUTOKUNBO	Responsible Doctor	LITTMAN, MARIO, MD
Account Number	FA1307223089	Location	FI4PVA
Unit Number	F001250247		
Age/Sex	37/M	Room	411
Status	DIS IN	Bed	02
		Registered Date	10/07/16
		Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/29/16	1800	FIHALLAM	Y			1	
		Dose: 50 MG					
10/29/16	2214	FISKANEK	Y			1	
		Dose: 50 MG					
10/30/16	0209	FISKANEK	Y			1	
		Dose: 50 MG					
10/31/16	0353	FITAGOED	Y			1	
		Dose: 50 MG					
10/31/16	1140	FIMOSLEK	Y			1	
		Dose: 50 MG					
10/31/16	1600	FIMOSLEK	Y			1	
		Dose: 50 MG					
11/01/16	0230	FITAGOED	Y			1	
		Dose: 50 MG					
11/01/16	1047	FIHALLAM	Y			1	
		Dose: 50 MG					
11/01/16	1735	FIHALLAM	Y			1	
		Dose: 50 MG					
Admin Totals						9	

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Patient	EFUNNUGA OLUTOKUNBO	Responsible Doctor	LITTMAN, MARIO, MD
Account Number	FA1307223089	Location	FI4PVA
Age/Sex	37/M	Room	411
Status	DIS IN	Bed	02
		Unit Number	F001250247
		Registered Date	10/07/16
		Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

SODI1TAB - Sodium Chloride 1 GM TABLET

Dose 1 GM (1 TABLET)

Admin Route PO

Start Date 10/29/16-1800

Stop Date 10/29/16 1801

DC Date 10/29/16-1801

Ordering Doctor JADHAV, GAURAV P MD

Total Dispensed 1

Total Costs \$0.10

Total Charges \$1.15

Rx Number 001897705

Discontinue Comments Reached Stop Date

## History

10/29/16 1732 - POM ORDER

by COJADHAG

10/29/16 1732 - EDIT

by FILINC

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

10/29/16 1732 - VERIFIED

by FILINC

10/29/16 1801 - DISCONTINUE

by PHABKGJOB

Eff: 10/29/16 1801

FROM:

DC COMMENTS:

TO:

DC COMMENTS:

Reached Stop Date

10/29/16 1806 - DEBIT

by FILINC

ITEMS: 1 DOSES: 1

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
10/29/16	1821	FIHALLAM	Y			1	0.00
(10/29/16) (1800) Dose: 1 GM							

Admin Totals

1

0

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 USER: MT Medication Administration Summary

Patient **EFUNNUGA OLUTOKUNBO** Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089** Location **FI4PVA** Unit Number **F001250247**  
 Age/Sex **37/M** Room **411** Registered Date **10/07/16**  
 Status **DIS IN** Bed **02** Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO FA1307223089 (Continued)

SODI10DI20 - 0.9 % SODIUM CHLORIDE 10 ML INJECTION

Dose 3 ML (0.3 INJECTIONS)  
 Admin Route IV  
 Start Date 10/07/16-1300 Stop Date None DC Date  
 Ordering Doctor **BORIKAR, MADHURA S MD**  
 Total Dispensed Total Costs \$ Total Charges \$  
 Rx Number U001131728

History  
 10/07/16 0816 - POM ORDER by COBORIKM  
 10/07/16 0828 - CANCEL by FIJASINT  
 EDIT DOCTOR: BORIKAR, MADHURA S MD

SODI10DI20 - 0.9 % SODIUM CHLORIDE 10 ML INJECTION

Dose 3 ML (0.3 INJECTIONS)  
 Admin Route IV  
 Frequency PRN (PRN) PAR= PRN REASON: FIV - FLUSHING IV LINE  
 Start Date 10/07/16-0815 Stop Date None DC Date  
 Ordering Doctor **BORIKAR, MADHURA S MD**  
 Total Dispensed Total Costs \$ Total Charges \$  
 Rx Number U001131729

History  
 10/07/16 0816 - POM ORDER by COBORIKM  
 10/07/16 0828 - CANCEL by FIJASINT  
 EDIT DOCTOR: BORIKAR, MADHURA S MD



DATE: 11/03/16 @ 0002  
USER: MT

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Patient	EFUNNUGA, OLUTOKUNBO		Responsible Doctor	LITTMAN, MARIO, MD	
Account Number	FA1307223089	Location	FI4PVA	Unit Number	F001250247
Age/Sex	37/M	Room	411	Registered Date	10/07/16
Status	DIS IN	Bed	02	Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

RISPLTAB - risperidONE 1 MG TABLET

Dose 0.5 MG (0.5 TABLETS)

Admin Route PO

Start Date 10/12/16-2100

Stop Date None

DC Date

Ordering Doctor ZHANG, HONGYU MD

Total Dispensed

Total Costs \$

Total Charges \$

Rx Number U001135466

#### History

10/12/16 1215 - POM ORDER

by COZHANGH

10/12/16 1312 - CANCEL

by FILINC

EDIT DOCTOR: ZHANG, HONGYU MD

FROM:

CANCEL COMMENTS:

TO:

CANCEL COMMENTS:

NEW ORDER BID

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 USER: MT      Medication Administration Summary

Patient **EFUNNUGA, OLUTOKUNBO**      Responsible Doctor **LITTMAN, MARIO, MD**  
 Account Number **FA1307223089**      Location **FI4PVA**      Unit Number **F001250247**  
 Age/Sex **37/M**      Room **411**      Registered Date **10/07/16**  
 Status **DIS IN**      Bed **02**      Discharged Date **11/01/16**

EFUNNUGA, OLUTOKUNBO      FA1307223089      (Continued)

**ACET600C - Acetylcysteine 600 MG CAPSULE**

Dose      600 MG (1 CAPSULE)  
 Admin Route **PO**  
 Start Date **10/18/16-1015**      Stop Date **None**      DC Date  
 Ordering Doctor **GOOCH, JOHN R MD**  
 Total Dispensed      Total Costs \$      Total Charges \$  
 Rx Number **U001139433**

**Warnings**

Type: **MAINTENANCE**  
 Range: **ACETYLCYSTEINE (600 MG)**  
 Condition: **ALL COMMON INDICATIONS**  
 Daily Dose      This is an exact dosage calculation of 600 MG/DAY Ordered dose of  
                          1,200 MG/DAY exceeds the exact dose by 600 MG/DAY.  
 Renal      The Patient's GLOMERULAR FILTRATION RATE is > 60. The result can not  
                          be compared against the threshold.

**History**

10/18/16 1014 - POM ORDER      by COGOOCHJ  
 10/18/16 1014 - NOW DOSE      by COGOOCHJ  
     Now Dose: 10/18/16 1015  
 10/18/16 1014 - KEEP NEXT DOSE      by COGOOCHJ  
     Keep Next Dose: 10/18/16 2100  
 10/18/16 1024 - CANCEL      by FIREALID  
     EDIT DOCTOR: GOOCH, JOHN R MD  
     FROM:  
     CANCEL COMMENTS:  
     TO:  
     CANCEL COMMENTS:  
     need IV; will d\c po

DATE: 11/03/16 @ 0002  
USER: MT

Mercy Fitzgerald Hospital PHA \*LIVE\*  
Medication Administration Summary

PAGE 227

Patient	EFUNNUGA, OLUTOKUNBO	Responsible Doctor	LITTMAN, MARIO, MD
Account Number	FA1307223089	Location	FI4PVA
Age/Sex	37/M	Room	411
Status	DIS IN	Bed	02
		Unit Number	F001250247
		Registered Date	10/07/16
		Discharged Date	11/01/16

EFUNNUGA, OLUTOKUNBO

FA1307223089

(Continued)

ENOX40DI - ENOXAPARIN SODIUM 40 MG/0.4 ML DISP.SYRIN

Dose 40 MG (0.4 ML)

Admin Route SUBQ

Start Date 10/25/16-1030

Stop Date None

DC Date

Ordering Doctor THUMMALAPENTA, SIRISHA MD

Total Dispensed

Total Costs \$

Total Charges \$

Rx Number U001144231

#### History

10/25/16 1028 - POM ORDER

by COTHUMMS

10/25/16 1028 - NOW DOSE

by COTHUMMS

Now Dose: 10/25/16 1030

10/25/16 1028 - KEEP NEXT DOSE

by COTHUMMS

Keep Next Dose: 10/26/16 0900

10/25/16 1030 - CANCEL

by FIREALID

EDIT DOCTOR: THUMMALAPENTA, SIRISHA MD

FROM:

CANCEL COMMENTS:

TO:

CANCEL COMMENTS:

dup

This is the end of the MAR Summary for Patient FA1307223089 - EFUNNUGA, OLUTOKUNBO.

MARIO LITTMAN, M.D., F.A.C.P.  
DEA # [redacted] LIC # MD-034443-E NPI # 1568400612  
SAM HAMID, M.D.  
DEA # [redacted] LIC # MD-423858 NPI # 1225077985  
7300 CITY ONE AVENUE, SUITE 203  
PHILADELPHIA, PA 19151  
(215) 878-7050  
NAME Olutokumbo Efunmike  
ADDRESS \_\_\_\_\_ DATE 11/1/16  
TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

R

Tramadol

50mg

1 po  
Q4H PRN  
#30

- ☐ 1-24
  - ☒ 25-49
  - ☐ 50-74
  - ☐ 75-100
  - ☐ 101-150
  - ☐ 151 and over
- Units

☐ LABEL  
Refill NR 1 2 3 4 5

SUBSTITUTION PERMISSIBLE  
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED,  
THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY"  
OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b>	
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED	
				Age: <u>37</u> Gender: <u>Male</u>	
				Care Unit: <u>ICU 5 PHILION</u> Shift: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS					
DATE	TIME	FAXED	<b>ORDERS</b>		
1			<b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b>		
2			Restraint Assessment and Physician Order		
3			<input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment		
4			<b>(Nursing to Complete):</b>		
5			<b>A. Nursing Assessment:</b>		
6			Describe current behavior:		
7			<input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings <input checked="" type="checkbox"/> Other <u>Agitation</u>		
8			<b>B. Alternatives Tried</b>		
9			<input checked="" type="checkbox"/> Companionship: family, friend volunteer <input checked="" type="checkbox"/> Decrease Stimuli/Noise Reduction <input type="checkbox"/> Skin Sleeve <input checked="" type="checkbox"/> Modify environment <input checked="" type="checkbox"/> Increased checks and observation <input checked="" type="checkbox"/> Close Observation <input checked="" type="checkbox"/> Bed alarm <input checked="" type="checkbox"/> Toileting/Hydration (q 2 hours while awake) <input checked="" type="checkbox"/> Medication <input checked="" type="checkbox"/> Reviewed/Assessed Medications and Lab values <input checked="" type="checkbox"/> Diversion/Activity/Busy Box <input checked="" type="checkbox"/> Assessed for underlying problem <input checked="" type="checkbox"/> Positioning Pillows <input checked="" type="checkbox"/> Assistance with toileting <input type="checkbox"/> Other: _____		
10			RN Signature: <u>Alpassin</u> Date: <u>10/19/16</u> Time: <u>0500</u>		
11			<b>PHYSICIAN ORDERS (Physician to Complete):</b>		
12			<b>A. Clinical Justification:</b>		
13			<input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.		
14			<b>B. Time:</b>		
15			APPLY FROM (TIME) <u>0500</u> AM/PM TO (TIME) <u>0506</u> AM/PM - 24 HOUR MAXIMUM		
16			<b>C. Type of restraint:</b>		
17			<input checked="" type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Gerri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Siderails		
18			<b>D. <input checked="" type="checkbox"/> Attending physician notified of restraint</b>		
19			<b>E. Signatures:</b>		
20			Date: <u>10/19/16</u> Time: _____ Physician <u>[Signature]</u>		
21			Date: <u>10/19/16</u> Time: <u>0500</u> Nurse Signature and title <u>Alyson Ross</u> Beep# _____		
22			Date: _____ Time: _____ Unit Secretary Signature _____		
23					

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff.

PLEASE NOTE!!!

DO NOT WRITE ON REVERSE SIDE OF THIS FORM.

**Mercy Fitzgerald Hospital**  
A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089

MR#: F001250247



## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

Moxles

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: See Section BPlan of care implemented as above: Nurse's Signature [Signature]

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff/Observer Signature
0500	12,3,5	A, D	RA LA RL LL	Circ, Rom, Ativan as per c/wa	[Signature]
0700	6,10	A, D	RA LA RL LL	Circ, Rom, MC, Suctioned	[Signature]
0900	7,10	A, D	RA LA RL LL	Arm Care Rom TYR [unclear]	[Signature]
1100	10	A, D	RA LA RL LL	MD	[Signature]
1300	10	A, D	RA LA RL LL	MD	[Signature]
1500	6,7	A, D	RA LA RL LL	MD - [unclear] - [unclear]	[Signature]
1700	6,7	A, D	RA LA RL LL	MD - [unclear] - [unclear]	[Signature]
1900	8	A, D	RA LA RL LL	MD - [unclear] - [unclear]	[Signature]
2100	6	A, D	RA LA RL LL	MD - [unclear] - [unclear]	[Signature]
0100	10	A, D	RA LA RL LL	MD - [unclear] - [unclear]	[Signature]
0300	10	A, D	RA LA RL LL	MD - [unclear] - [unclear]	[Signature]
0500			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/19/16 Time: 0800☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature [Signature]Evening/PM Shift: Date: 10/19/16 Time: 2000☐ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature [Signature]Night/PM Shift: Date: 10/20/16 Time: 0100☐ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature [Signature]

PT Remand  
 Kio Fall + 1!!  
 CMO @ 31

D. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☒ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/DrainsDate 10/20/16 Time of Restraint Release 0400 Nurse's Signature [Signature]

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

Mercy Fitzgerald Hospital  
 A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERFI





## A. (Nursing to Complete):

- ☐ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☐ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE.

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES.

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: See page #1Plan of care implemented as above: Nurse's Signature EFUNNUGA

Time every 2 Hours	Behavior Key	Type Code	Circle Limbs Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
1715	5	A10	RA LA RL LL	blc sun plead	EFUNNUGA
1915	7	A10	RA LA RL LL	pull on, pull on, Foley	EFUNNUGA
2115	10	A10	RA LA RL LL	turn, pull on car up	EFUNNUGA
2315	10	A10	RA LA RL LL	circ / turned / mc / sx / pom	C. Burke RN
0115	5, 4	A10	RA LA RL LL	circ / turned / partial bath / mc / sx / pom	C. Burke RN
0315	10	A10	RA LA RL LL	circ / turned / bath / mc / sx / pom	C. Burke RN
0515	4, 5	A10	RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
0715	7, 10	A10	RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
0915	1, 5	A10	RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
1115			RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
			RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
			RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
			RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
			RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN
			RA LA RL LL	circ / bath / pulled A line out / sx / pom	C. Burke RN

## C. Reassessment: NURSES REASSESS EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/25/16 Time: 0815☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature EFUNNUGAEvening/PM Shift: Date: 10/25/16 Time: 1715☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature EFUNNUGANight/PM Shift: Date: 10/25/16 Time: 0115☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature C. Burke RND. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/DrainsDate 10/25/16 Time of Restraint Release 1715 Nurse's Signature EFUNNUGA

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERF1



PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b>	
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED	
				Age: _____ Gender: _____	
				Care Unit: _____ Shift: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS					
	DATE	TIME	FAXED	<b>ORDERS</b>	
1				<b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b>	
2				Restraint Assessment and Physician Order	
3				<input checked="" type="checkbox"/> Initial Assessment <input type="checkbox"/> Reassessment	
4				<b>(Nursing to Complete):</b>	
5				<b>A. Nursing Assessment:</b>	
6				Describe current behavior:	
7				<input type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings	
8				<input checked="" type="checkbox"/> Other <u>See Mental Status</u>	
9				<b>B. Alternatives Tried</b>	
10				<input type="checkbox"/> Companionship: family, friend volunteer	
11				<input type="checkbox"/> Skin Sleeve	
12				<input checked="" type="checkbox"/> Increased checks and observation	
13				<input checked="" type="checkbox"/> Bed alarm	
14				<input checked="" type="checkbox"/> Medication	
15				<input type="checkbox"/> Diversion/Activity/Busy Box	
16				<input type="checkbox"/> Positioning Pillows	
17				<input type="checkbox"/> Other: _____	
18				<input checked="" type="checkbox"/> Decrease Stimuli/Noise Reduction	
19				<input checked="" type="checkbox"/> Modify environment	
20				<input checked="" type="checkbox"/> Close Observation	
21				<input checked="" type="checkbox"/> Toileting/Hydration (q 2 hours while awake)	
22				<input checked="" type="checkbox"/> Reviewed/Assessed Medications and Lab values	
23				<input checked="" type="checkbox"/> Assessed for underlying problem	
				<input type="checkbox"/> Assistance with toileting	
				RN Signature: <u>[Signature]</u> Date: <u>10/7/2016</u> Time: <u>2000</u>	
				<b>PHYSICIAN ORDERS (Physician to Complete):</b>	
				<b>A. Clinical Justification:</b>	
				<input type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.	
				<b>B. Time:</b> <u>147/2016</u> <u>10/8/2016</u>	
				APPLY FROM (TIME) <u>2000</u> AM/PM TO (TIME) <u>2000</u> AM/PM - 24 HOUR MAXIMUM	
				<b>C. Type of restraint:</b>	
				<input checked="" type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point	
				<input type="checkbox"/> Geri Chair with Tray	
				<input type="checkbox"/> Peek-a-boo Mitts	
				<input type="checkbox"/> 3-4 Siderails	
				<b>D. <input checked="" type="checkbox"/> Attending physician notified of restraint</b>	
				<b>E. Signatures:</b>	
				Date: <u>10/7</u> Time: <u>2000</u> Physician: <u>[Signature]</u>	
				Date: <u>10/7</u> Time: <u>2000</u> Nurse Signature and title: <u>[Signature]</u> Beeper# _____	
				Date: _____ Time: _____ Unit Secretary Signature: _____	

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutics Committee of the Medical Staff.

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RESTRAINTS (NON-VIOLENT)

I ASM.X.OTHERF1

Page 1 of 2  
Form #PF719, Rev. 01/2008  
ASM.X.OTHER

EFUNNUGA, OLUTOKUNBO  
DOB: 03/06/1979 37Y M  
Adm: 10/7/2016  
Acc: FA1307223089 MR#: F001250247



## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior.

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: See pg 1 See BPlan of care Implemented as above: Nurse's Signature M. Bright

Time every 2 Hours	Behavior Key	Type Code	Circle Limbs Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
800	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
800	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
0000	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
0200	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
0400	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
0600	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
0800	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
1000	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
1200	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
1400	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
1600	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
1800	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
2000	7,10	A,D	RA LA RL LL	Triceps, good pulses	<u>[Signature]</u>
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/8/16 Time: 1800☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature M. BrightEvening/PM Shift: Date: 10/8 Time: 10☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature [Signature]Night/PM Shift: Date: 10/8 Time: 20☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature [Signature]D. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/DrainsDate 10/8/16 Time of Restraint Release 10:00 Nurse's Signature [Signature]Total Time Restrained:                      Hours                      Minutes                     

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



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6

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b>	
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED	
				Age: _____ Gender: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS				Care Unit: _____ Shift: _____	
DATE	TIME	FAXED	<b>ORDERS</b>		
1.			<b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b>		
2.			Restraint Assessment and Physician Order		
3.			<input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment		
4.	10/9/16	22:00	<b>(Nursing to Complete):</b> <b>A. Nursing Assessment:</b> Describe current behavior: <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings <input type="checkbox"/> Other _____		
5.			<b>B. Alternatives Tried</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input checked="" type="checkbox"/> Companionship: family, friend volunteer  <input type="checkbox"/> Skin Sleeve  <input checked="" type="checkbox"/> Increased checks and observation  <input checked="" type="checkbox"/> Bed alarm  <input checked="" type="checkbox"/> Medication  <input type="checkbox"/> Diversion/Activity/Busy Box  <input checked="" type="checkbox"/> Positioning Pillows  <input type="checkbox"/> Other: _____         </div> <div style="width: 48%;"> <input checked="" type="checkbox"/> Decrease Stimuli/Noise Reduction  <input checked="" type="checkbox"/> Modify environment  <input type="checkbox"/> Close Observation  <input checked="" type="checkbox"/> Toileting/Hydration (q 2 hours while awake)  <input checked="" type="checkbox"/> Reviewed/Assessed Medications and Lab values  <input checked="" type="checkbox"/> Assessed for underlying problem  <input checked="" type="checkbox"/> Assistance with toileting         </div> </div>		
6.			RN Signature: <u>Daniel McDuff BW</u> Date: <u>10/9/16</u> Time: <u>22:00</u>		
7.			<b>PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.		
8.			<b>B. Time:</b> APPLY FROM (TIME) <u>22:00</u> AM/PM TO (TIME) <u>22:00</u> AM/PM - 24 HOUR MAXIMUM		
9.			<b>C. Type of restraint:</b> <input checked="" type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Geri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Siderails		
10.			<b>D.</b> <input type="checkbox"/> Attending physician notified of restraint		
11.			<b>E. Signatures:</b> Date: <u>10/9</u> Time: <u>22:00</u> Physician <u>[Signature]</u> Date: <u>10/9</u> Time: <u>22:00</u> Nurse Signature and title <u>Daniel McDuff BW</u> <b>Beeper#</b> _____ Date: _____ Time: _____ Unit Secretary Signature _____		

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERF



## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: See page 1 section BPlan of care implemented as above: Nurse's Signature [Signature]

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
22:00	7, 10	A.D	(RA) (LA) RL LL	Room, Repositioned, @ Pulses	[Signature]
00:00	7, 10	A.D	(RA) (LA) RL LL	Room, Repositioned, @ Pulses	[Signature]
02:00	7, 10	A.D	(RA) (LA) RL LL	Room, Repositioned, @ Pulses	[Signature]
04:00	5	A.D	(RA) (LA) RL LL	Room, Repositioned, @ Pulses	[Signature]
06:00	7, 10	A.D	(RA) (LA) RL LL	Room, Repositioned, @ Pulses	[Signature]
08:00	7, 10	A.D	(RA) (LA) RL LL	Suction Turn monitor case + pp	[Signature]
10:00	10	A.D	(RA) (LA) RL LL	Turn EEG @ pp Room	[Signature]
12:00	7	A.D	(RA) (LA) RL LL	Linear Change Suction Monitor case	[Signature]
14:00	10	A.D	(RA) (LA) RL LL	Linear Suction Monitor	[Signature]
16:00	5	A.D	(RA) (LA) RL LL	T+A, nutra, @ Pulse	[Signature]
18:00	5	A.D	(RA) (LA) RL LL	T+A, nutra, @ Pulse	[Signature]
20:00	5	A.D	(RA) (LA) RL LL	T+A, nutra, @ Pulse	[Signature]
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/10/16 Time: 7A☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature [Signature]Evening/PM Shift: Date: 10/10/16 Time: 1600☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature [Signature]

Night/PM Shift: Date: \_\_\_\_\_ Time: \_\_\_\_\_

☐ Continue Restraints as warranted by patient's condition as assessed and documented

Nurse's Signature \_\_\_\_\_

D. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/Drains

Date \_\_\_\_\_ Time of Restraint Release \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Total Time Restrained: \_\_\_\_\_ hours \_\_\_\_\_ Minutes

Mercy Fitzgerald Hospital  
 A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089

MR#: F001250247



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6

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b>	
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED	
				Age: _____ Gender: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS				Care Unit: _____ Shift: _____	

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY	
1			<div style="text-align: center;"><b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b>            Restraint Assessment and Physician Order  <input type="checkbox"/> Initial Assessment    <input checked="" type="checkbox"/> Reassessment   <b>(Nursina to Complete):</b>  <b>A. Nursing Assessment:</b>            Describe current behavior:  <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings  <input type="checkbox"/> Other _____   <b>B. Alternatives Tried</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Companionship: family, friend volunteer  <input type="checkbox"/> Skin Sleeve  <input type="checkbox"/> Increased checks and observation  <input type="checkbox"/> Bed alarm  <input checked="" type="checkbox"/> Medication  <input type="checkbox"/> Diversion/Activity/Busy Box  <input type="checkbox"/> Positioning Pillows  <input type="checkbox"/> Other: _____               </div> <div> <input type="checkbox"/> Decrease Stimuli/Noise Reduction  <input type="checkbox"/> Modify environment  <input type="checkbox"/> Close Observation  <input type="checkbox"/> Toileting/Hydration (q 2 hours while awake)  <input type="checkbox"/> Reviewed/Assessed Medications and Lab values  <input type="checkbox"/> Assessed for underlying problem  <input type="checkbox"/> Assistance with toileting               </div> </div> </div>		
2					
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4					
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7					
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21					
22					
23					

<b>PHYSICIAN ORDERS (Physician to Complete):</b>	
<b>A. Clinical Justification:</b>	
<input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.	
<b>B. Time:</b>	
APPLY FROM (TIME) <u>2200</u> AM/PM TO (TIME) <u>2200</u> AM/PM - 24 HOUR MAXIMUM	
<b>C. Type of restraint:</b>	
<input type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Geri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Siderails	
<b>D. <input type="checkbox"/> Attending physician notified of restraint</b>	
<b>E. Signatures:</b>	
Date: _____ Time: _____	Physician <u>[Signature]</u>
Date: <u>10/10/18</u> Time: <u>2200</u>	Nurse Signature and title <u>[Signature]</u> Beeper# _____
Date: _____ Time: _____	Unit Secretary Signature _____

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff

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**Mercy Fitzgerald Hospital**  
 A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



iASM.X.OTHERF

## A. (Nursing to Complete):

- ☐ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☐ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: See pg 7 See pg 1Plan of care implemented as above: Nurse's Signature LSHON

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
2300	5	A10	RA LA RL LL	TTR, mouth care, position	LSHON
0000	6	A10	RA LA RL LL		LSHON
0200	10	A10	RA LA RL LL		LSHON
0400	10	A10	RA LA RL LL	AM care	LSHON
0600	10	A10	RA LA RL LL		LSHON
0800	10	A10	RA LA RL LL	SBT SAT suction	LSHON
1000	6-7	A10	RA LA RL LL	Suction 2 times + pp skin care 15 min	LSHON
1200	10	A10	RA LA RL LL	Suction 2 (pp) pp skin care 15 min	LSHON
1400	10	A10	RA LA RL LL	Condom, cold turn mobile care 15 min	LSHON
1600	10	A10	RA LA RL LL	Position, pulse	LSHON
1800	10	A10	RA LA RL LL	TTR, mouth, mouth care	LSHON
2000	1	A10	RA LA RL LL	TTR, straight care, position	LSHON
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/11/16 Time: 7A☐ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature LSHONEvening/PM Shift: Date: 11/11/16 Time: 1600☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature LSHONNight/PM Shift: Date: 10/11/16 Time: 0700☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature LSHOND. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings      ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/DrainsDate 10/11/16 Time of Restraint Release 0700 Nurse's Signature LSHON

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

Mercy Fitzgerald Hospital  
 A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERFI



680

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b>	
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED	
				Age: _____ Gender: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS				Care Unit: _____ Shift: _____	

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY
10/12/16	2300		<b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b> Restraint Assessment and Physician Order <input type="checkbox"/> Initial Assessment <input type="checkbox"/> Reassessment  <b>(Nursing to Complete):</b> <b>A. Nursing Assessment:</b> Describe current behavior: <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings <input type="checkbox"/> Other _____  <b>B. Alternatives Tried</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> Companionship: family, friend volunteer  <input type="checkbox"/> Skin Sleeve  <input checked="" type="checkbox"/> Increased checks and observation  <input type="checkbox"/> Bed alarm  <input type="checkbox"/> Medication  <input type="checkbox"/> Diversion/Activity/Busy Box  <input type="checkbox"/> Positioning Pillows  <input type="checkbox"/> Other: _____           </div> <div style="width: 48%;"> <input type="checkbox"/> Decrease Stimuli/Noise Reduction  <input type="checkbox"/> Modify environment  <input checked="" type="checkbox"/> Close Observation  <input type="checkbox"/> Toileting/Hydration (q 2 hours while awake)  <input type="checkbox"/> Reviewed/Assessed Medications and Lab values  <input type="checkbox"/> Assessed for underlying problem  <input type="checkbox"/> Assistance with toileting           </div> </div> RN Signature: <u>U. D. Amato</u> Date: <u>10/12</u> Time: <u>2300</u>	
			<b>PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.  <b>B. Time:</b> APPLY FROM (TIME) <u>2300</u> AM/PM TO (TIME) <u>2300</u> AM/PM - 24 HOUR MAXIMUM  <b>C. Type of restraint:</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Soft Limb:  <input type="checkbox"/> Geri Chair with Tray  <input type="checkbox"/> Peek-a-boo Mitts  <input checked="" type="checkbox"/> 3-4 Siderails           </div> <div style="width: 50%;"> <input type="checkbox"/> 1 Point    <input checked="" type="checkbox"/> 2 Point    <input type="checkbox"/> 3 Point           </div> </div> <b>D.</b> <input checked="" type="checkbox"/> Attending physician notified of restraint  <b>E. Signatures:</b> Date: <u>10/12</u> Time: <u>2300</u> Physician: <u>[Signature]</u> Date: <u>10/12</u> Time: <u>2300</u> Nurse Signature and title: <u>[Signature]</u> Beeper#: _____ Date: _____ Time: _____ Unit Secretary Signature: _____	

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff

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A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

IASM.X.OTHERF1

EFUNNUGA, OLUTOKUNBO  
 DOB: 03/06/1979 37Y M  
 Adm: 10/7/2016  
 Acc: FA1307223089 MR#: F001250247



## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: as abovePlan of care implemented as above: Nurse's Signature V. Olumade

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
2300	5	A, D	(RA) (LA) RL LL	Repositioned to R	V. Olumade RN
0100	6	A, D	(RA) (LA) RL LL	Repositioned	V. Olumade
0300	10	A, D	(RA) (LA) RL LL	Repositioned straight back	V. Olumade
0500	10	A, D	(RA) (LA) RL LL	Repositioned	V. Olumade
0700	10	A, D	(RA) (LA) RL LL	Repositioned	V. Olumade
09	10	A, D	(RA) (LA) RL LL	Repositioned TF Suction mod & care - 15.10.18	V. Olumade
11	5	A, D	(RA) (LA) RL LL	Repositioned TF mod & care - 15.10.18	V. Olumade
13	5	A, D	(RA) (LA) RL LL	Repositioned TF Suction - 15.10.18	V. Olumade
15	6	A, D	(RA) (LA) RL LL	SWR rep	V. Olumade
17	6	A, D	(RA) (LA) RL LL	SWR rep	V. Olumade
19	6	A, D	(RA) (LA) RL LL	SWR rep	V. Olumade
21	6	A, D	(RA) (LA) RL LL	SWR rep	V. Olumade
23	6	A, D	(RA) (LA) RL LL	SWR rep	V. Olumade
			RA LA RL LL		

## C. Reassessment: NURSES REASSESS EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/13/16 Time: 7:00☐ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature V. Olumade

Evening/PM Shift: Date: \_\_\_\_\_ Time: \_\_\_\_\_

☐ Continue Restraints as warranted by patient's condition as assessed and documented

Nurses Signature \_\_\_\_\_

Night/PM Shift: Date: 10/13/16 Time: 0700☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature V. OlumadeD. RESTRAINTS DISCONTINUATION: patient meets criteria for removal : ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings    ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/Drains

Date \_\_\_\_\_ Time of Restraint Release \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO 506  
 DOB: 03/06/1979 37Y M  
 Adm: 10/7/2016  
 Acc: FA1307223089 MR#: F001250247



1ASM.X.OTHERF1



PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b> THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED Age: _____ Gender: _____ Care Unit: _____ Shift: _____																															
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS																																			
DATE	TIME	FAXED	ORDERS																																
			TRANSCRIBED BY																																
			<b>PART I BEHAVIORAL RESTRAINT ASSESSMENT FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR</b> <input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment <b>(Nursing to Complete):</b> <b>A. Nursing Assessment:</b> <table style="width:100%;"> <tr> <td><input checked="" type="checkbox"/> Severe Agitation</td> <td><input type="checkbox"/> Assaultive/ Risk of Injury</td> </tr> <tr> <td><input type="checkbox"/> Combative/Striking Out</td> <td><input type="checkbox"/> Violent/ Aggressive Behavior</td> </tr> <tr> <td><input type="checkbox"/> Self-Abusive</td> <td><input checked="" type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis</td> </tr> <tr> <td><input checked="" type="checkbox"/> Suicidal</td> <td><input type="checkbox"/> Persistent aggressive verbal threats</td> </tr> <tr> <td><input type="checkbox"/> Throwing Objects</td> <td><input checked="" type="checkbox"/> Hitting/ Kicking/ Biting</td> </tr> <tr> <td><input type="checkbox"/> Damaging Property</td> <td><input checked="" type="checkbox"/> Behavior Dangerous to Self or Others</td> </tr> <tr> <td><input type="checkbox"/> Self-Mutilating</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <b>B. Identify the less-restrictive alternatives tried in order to modify behaviors:</b> <table style="width:100%;"> <tr> <td><input type="checkbox"/> De-escalation</td> <td><input checked="" type="checkbox"/> Calming Medication</td> <td><input checked="" type="checkbox"/> 1:1 Observation</td> <td><input checked="" type="checkbox"/> Set Clear, Firm Limits</td> </tr> <tr> <td><input type="checkbox"/> PEAT Code</td> <td><input type="checkbox"/> Family Members</td> <td><input checked="" type="checkbox"/> Diversion/Activity</td> <td><input type="checkbox"/> Quiet Room / Time-Out</td> </tr> <tr> <td><input checked="" type="checkbox"/> Active Listening</td> <td><input checked="" type="checkbox"/> Allow to Ventilate</td> <td><input checked="" type="checkbox"/> Minimum Stimulation</td> <td><input checked="" type="checkbox"/> Offer Alternatives / Choices</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Other/Describe: _____</td> </tr> </table> <b>C. Patient's Response to Above Alternatives:</b> <u>Unresponsive</u>  The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>Alyson Rossini RN</u> Date: <u>10/17/16</u> Time: <u>2000</u> <b>PART II PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input checked="" type="checkbox"/> Imminent danger of harm to self or others <input checked="" type="checkbox"/> Combative/ Assaultive/ Violent behavior <input checked="" type="checkbox"/> Other: <u>Attempt to elope previous shift</u> <b>B. Time:</b> Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>2000</u> AM/PM TO (TIME) <u>0000</u> AM/PM <b>C. Type of restraint:</b> <input type="checkbox"/> Locked Seclusion (Psychiatric Units Only) <input checked="" type="checkbox"/> 3-4 Side rails <input checked="" type="checkbox"/> Locked Velcro Restraints <input checked="" type="checkbox"/> 4 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> 2 Point <input type="checkbox"/> Soft Limb <input type="checkbox"/> 4 Point <input type="checkbox"/> Other <b>D. Continuous observation face-to-face by assigned staff for duration of episode.</b> Note: Face-to-face LIP / Physician visit must be completed within one hour and progress note written. <b>E. Signatures:</b> Date: <u>10/17/16</u> Time: <u>8 PM</u> Licensed Independent Practitioner Signature: _____ Pager# _____ Date: _____ Time: _____ Unit Secretary Signature: _____ Date: <u>10/17/16</u> Time: <u>2000</u> Registered Nurse Signature: <u>Alyson Rossini RN</u> <input type="checkbox"/> If verbal order, read back and verified by _____ RN			<input checked="" type="checkbox"/> Severe Agitation	<input type="checkbox"/> Assaultive/ Risk of Injury	<input type="checkbox"/> Combative/Striking Out	<input type="checkbox"/> Violent/ Aggressive Behavior	<input type="checkbox"/> Self-Abusive	<input checked="" type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis	<input checked="" type="checkbox"/> Suicidal	<input type="checkbox"/> Persistent aggressive verbal threats	<input type="checkbox"/> Throwing Objects	<input checked="" type="checkbox"/> Hitting/ Kicking/ Biting	<input type="checkbox"/> Damaging Property	<input checked="" type="checkbox"/> Behavior Dangerous to Self or Others	<input type="checkbox"/> Self-Mutilating	<input type="checkbox"/> Other: _____	<input type="checkbox"/> De-escalation	<input checked="" type="checkbox"/> Calming Medication	<input checked="" type="checkbox"/> 1:1 Observation	<input checked="" type="checkbox"/> Set Clear, Firm Limits	<input type="checkbox"/> PEAT Code	<input type="checkbox"/> Family Members	<input checked="" type="checkbox"/> Diversion/Activity	<input type="checkbox"/> Quiet Room / Time-Out	<input checked="" type="checkbox"/> Active Listening	<input checked="" type="checkbox"/> Allow to Ventilate	<input checked="" type="checkbox"/> Minimum Stimulation	<input checked="" type="checkbox"/> Offer Alternatives / Choices	<input type="checkbox"/> Other/Describe: _____			
<input checked="" type="checkbox"/> Severe Agitation	<input type="checkbox"/> Assaultive/ Risk of Injury																																		
<input type="checkbox"/> Combative/Striking Out	<input type="checkbox"/> Violent/ Aggressive Behavior																																		
<input type="checkbox"/> Self-Abusive	<input checked="" type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis																																		
<input checked="" type="checkbox"/> Suicidal	<input type="checkbox"/> Persistent aggressive verbal threats																																		
<input type="checkbox"/> Throwing Objects	<input checked="" type="checkbox"/> Hitting/ Kicking/ Biting																																		
<input type="checkbox"/> Damaging Property	<input checked="" type="checkbox"/> Behavior Dangerous to Self or Others																																		
<input type="checkbox"/> Self-Mutilating	<input type="checkbox"/> Other: _____																																		
<input type="checkbox"/> De-escalation	<input checked="" type="checkbox"/> Calming Medication	<input checked="" type="checkbox"/> 1:1 Observation	<input checked="" type="checkbox"/> Set Clear, Firm Limits																																
<input type="checkbox"/> PEAT Code	<input type="checkbox"/> Family Members	<input checked="" type="checkbox"/> Diversion/Activity	<input type="checkbox"/> Quiet Room / Time-Out																																
<input checked="" type="checkbox"/> Active Listening	<input checked="" type="checkbox"/> Allow to Ventilate	<input checked="" type="checkbox"/> Minimum Stimulation	<input checked="" type="checkbox"/> Offer Alternatives / Choices																																
<input type="checkbox"/> Other/Describe: _____																																			

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff.

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**Mercy Fitzgerald Hospital**  
A member of Mercy Health System

BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



**PART III NURSING CARE**

(Nursing to Complete):

**A. Family Notification / Patient and Family Education:**Name of Family Member notified: No family present @ this time Date/Time: 10/17/16☐ Pt. Refused☒ Unavailable

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention &amp; use were identified on Interdisciplinary Plan of Care / Team Treatment Plan.

RN Initials: AR**B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:**

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses &amp; good color, Skin Assessment &amp; Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

**Behavioral Key:**

1 = Threatening 2 = Combative

3 = Violent

4 = Assaultive

5 = Loud/Yelling

6 = Agitated

7 = Uncooperative 8 = Calmer

9 = Quiet

10 = Cooperative

11 = Medicated

12 = Ate (Describe)

13 = Drank (Describe)

14 = Other (See Comments)

Time every 15 min.	Behavior Key	Circle Restrained Limbs	Comments/Observations/Interventions	Assigned Staff Observer Signature
2000	7	RA (A) RL (L)	Circv, ROM, T+R Assessment, ST, Febrile	ARassend RN
2015	7	RA (A) RL (L)	Circv MC, Suctioned	ARassend RN
2030	9	RA (A) RL (L)	Circv Pen care	ARassend RN
2045	9	RA (A) RL (L)	Circv Back care, ST,	ARassend RN
2100	6, 7	RA (A) RL (L)	Circv ROM, Advise given as per CWA	ARassend RN
2115	8	RA (A) RL (L)	Circv MC, No Clp	ARassend RN
2130	8	RA (A) RL (L)	Circv Suctioned	ARassend RN
2145	8	RA (A) RL (L)	Circv, Appears asleep	ARassend RN
2200	8	RA (A) RL (L)	Circv ROM, T+R, MC, PM Care	ARassend RN
2215	8	RA (A) RL (L)	Circv, MC, Suctioned	ARassend RN
2230	8	RA (A) RL (L)	Circv, Suctioned, Fentanyl 50 mcg XT PR	ARassend RN
2245	9	RA (A) RL (L)	Circv ROM, Suctioned	ARassend RN
2300	9	RA (A) RL (L)	Circv ROM Skin care	ARassend RN
2315	9	RA (A) RL (L)	Circv MC USS	ARassend RN
2330	9	RA (A) RL (L)	Circv ROM USS	ARassend RN

**C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

☐ Continue Restraints☐ New order obtained

Signature/Title: \_\_\_\_\_

Vital Signs: Time \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_ BP. \_\_\_\_\_ / \_\_\_\_\_

**D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:**Criteria for Removal ☒ as appropriate, complete when released☐ Increased behavioral control ☐ No assaultive threats ☐ Demonstrates calm behavior ☐ Improved mental status ☐ Improved communication ☐ Other \_\_\_\_\_☐ Decreased agitation ☐ No threats of self harm ☐ Follows directions ☐ Interacts with staff ☐ Agrees to Safety Contract

Signature/Title: \_\_\_\_\_ Date Ended: \_\_\_\_\_ Time Ended: \_\_\_\_\_ AM/PM

**E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form**☐ Yes ☐ No**F. ☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.**Total Time Restrained: 2 Hours \_\_\_\_\_ MinutesMercy Fitzgerald Hospital  
A member of Mercy Health System

BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



**(Nursing to Complete):**

☐ Pt. RefusedDate/Time: 10/17/16

Unavailable

RN Initials: AK

RN Initials: AK

**Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:**

**Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.**

1 = Threatening    2 = Combative    3 = Violent    4 = Assaultive    5 = Loud/Yelling    6 = Agitated  
7 = Uncooperative    8 = Calmer    9 = Quiet    10 = Cooperative    11 = Medicated    12 = Ate (Describe)  
13 = Drank (Describe)    14 = Other (See Comments)

**C. Reassessment;** Nurse reassess the patient at the end of the time ordered or when released.

Date: 10/18/16 Time: 0000

It remains unreliable, impulsive, Attempts to strike when limbs are released.  
No verbalization of suicidal ideation present.

☒ Continue Restraints      ☒ New order obtained      Signature/Title: Kassard W

Vital Signs: Time 1000 T. 37.8 P. 91 R. 45 BP. 154 / 83

**D. Restraints Discontinued:** The patient has met the following criteria for restraint removal or release from locked seclusion:

**Criteria for Removal ☒ as appropriate, complete when released**

☐ Increased behavioral control    ☐ No assaultive threats    ☐ Demonstrates calm behavior    ☐ Improved mental status    ☐ Improved communication    ☐ Other  
☐ Decreased agitation    ☐ No threats of self harm    ☐ Follows directions    ☐ Interacts with staff    ☐ Agrees to Safety Contract

**Signature/Title:** \_\_\_\_\_ **Date Ended:** \_\_\_\_\_ **Time Ended:** \_\_\_\_\_ **AM/PM**

**E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form** ☐ Yes ☐ No

F. ☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.

Total Time Restrained: 4 Hours 0 Minutes

**Mercy Fitzgerald Hospital**  
A member of Mercy Health System

### BEHAVIORAL RESTRAINTS (VIOLENT)

**EFUNNUGA, OLUTOKUNBO**

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247





PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b> THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED Age: _____ Gender: _____ Care Unit: _____ Shift: _____						
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS										
DATE	TIME	FAXED	ORDERS							
			TRANSCRIBED BY							
			BEHAVIORAL RESTRAINT ASSESSMENT FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR							
			PART I <input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment (Nursing to Complete): A. Nursing Assessment: <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <input checked="" type="checkbox"/> Severe Agitation  <input type="checkbox"/> Combative/Striking Out  <input type="checkbox"/> Self-Abusive  <input checked="" type="checkbox"/> Suicidal  <input type="checkbox"/> Throwing Objects  <input type="checkbox"/> Damaging Property  <input type="checkbox"/> Self-Mutilating           </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Assaultive/ Risk of Injury  <input type="checkbox"/> Violent/ Aggressive Behavior  <input checked="" type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis  <input type="checkbox"/> Persistent aggressive verbal threats  <input checked="" type="checkbox"/> Hitting/Kicking/ Biting  <input checked="" type="checkbox"/> Behavior Dangerous to Self or Others  <input type="checkbox"/> Other: _____           </td> </tr> </table> B. Identify the less-restrictive alternatives tried in order to modify behaviors: <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> De-escalation  <input type="checkbox"/> PEAT Code  <input checked="" type="checkbox"/> Active Listening  <input type="checkbox"/> Other/Describe: _____           </td> <td style="width:33%; vertical-align: top;"> <input checked="" type="checkbox"/> Calming Medication  <input type="checkbox"/> Family Members  <input checked="" type="checkbox"/> Allow to Ventilate           </td> <td style="width:33%; vertical-align: top;"> <input checked="" type="checkbox"/> 1:1 Observation  <input type="checkbox"/> Diversion/Activity  <input checked="" type="checkbox"/> Minimum Stimulation  <input checked="" type="checkbox"/> Set Clear, Firm Limits  <input type="checkbox"/> Quiet Room / Time-Out  <input checked="" type="checkbox"/> Offer Alternatives / Choices           </td> </tr> </table> C. Patient's Response to Above Alternatives: <u>Unreceptive</u>			<input checked="" type="checkbox"/> Severe Agitation <input type="checkbox"/> Combative/Striking Out <input type="checkbox"/> Self-Abusive <input checked="" type="checkbox"/> Suicidal <input type="checkbox"/> Throwing Objects <input type="checkbox"/> Damaging Property <input type="checkbox"/> Self-Mutilating	<input type="checkbox"/> Assaultive/ Risk of Injury <input type="checkbox"/> Violent/ Aggressive Behavior <input checked="" type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis <input type="checkbox"/> Persistent aggressive verbal threats <input checked="" type="checkbox"/> Hitting/Kicking/ Biting <input checked="" type="checkbox"/> Behavior Dangerous to Self or Others <input type="checkbox"/> Other: _____	<input type="checkbox"/> De-escalation <input type="checkbox"/> PEAT Code <input checked="" type="checkbox"/> Active Listening <input type="checkbox"/> Other/Describe: _____	<input checked="" type="checkbox"/> Calming Medication <input type="checkbox"/> Family Members <input checked="" type="checkbox"/> Allow to Ventilate	<input checked="" type="checkbox"/> 1:1 Observation <input type="checkbox"/> Diversion/Activity <input checked="" type="checkbox"/> Minimum Stimulation <input checked="" type="checkbox"/> Set Clear, Firm Limits <input type="checkbox"/> Quiet Room / Time-Out <input checked="" type="checkbox"/> Offer Alternatives / Choices
<input checked="" type="checkbox"/> Severe Agitation <input type="checkbox"/> Combative/Striking Out <input type="checkbox"/> Self-Abusive <input checked="" type="checkbox"/> Suicidal <input type="checkbox"/> Throwing Objects <input type="checkbox"/> Damaging Property <input type="checkbox"/> Self-Mutilating	<input type="checkbox"/> Assaultive/ Risk of Injury <input type="checkbox"/> Violent/ Aggressive Behavior <input checked="" type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis <input type="checkbox"/> Persistent aggressive verbal threats <input checked="" type="checkbox"/> Hitting/Kicking/ Biting <input checked="" type="checkbox"/> Behavior Dangerous to Self or Others <input type="checkbox"/> Other: _____									
<input type="checkbox"/> De-escalation <input type="checkbox"/> PEAT Code <input checked="" type="checkbox"/> Active Listening <input type="checkbox"/> Other/Describe: _____	<input checked="" type="checkbox"/> Calming Medication <input type="checkbox"/> Family Members <input checked="" type="checkbox"/> Allow to Ventilate	<input checked="" type="checkbox"/> 1:1 Observation <input type="checkbox"/> Diversion/Activity <input checked="" type="checkbox"/> Minimum Stimulation <input checked="" type="checkbox"/> Set Clear, Firm Limits <input type="checkbox"/> Quiet Room / Time-Out <input checked="" type="checkbox"/> Offer Alternatives / Choices								
			The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>Alyson Passindri</u> Date: <u>10/18/16</u> Time: <u>0000</u>							
			PART II PHYSICIAN ORDERS (Physician to Complete): A. Clinical Justification: <input checked="" type="checkbox"/> Imminent danger of harm to self or others <input checked="" type="checkbox"/> Combative/ Assaultive/ Violent behavior <input type="checkbox"/> Other: _____							
			B. Time: Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>0000</u> AM/PM TO (TIME) <u>0400</u> AM/PM							
			C. Type of restraint: <input type="checkbox"/> Locked Seclusion (Psychiatric Units Only) <input checked="" type="checkbox"/> 3-4 Side rails <input checked="" type="checkbox"/> Locked Velcro Restraints <input type="checkbox"/> 4 Point <input checked="" type="checkbox"/> 3 Point <input type="checkbox"/> 2 Point <input type="checkbox"/> Soft Limb <input type="checkbox"/> 4 Point <input type="checkbox"/> Other							
			D. Continuous observation face-to-face by assigned staff for duration of episode. Note: Face-to-face LIP / Physician visit must be completed within one hour and progress note written.							
			E. Signatures: Date: <u>10/18</u> Time: <u>12AM</u> Licensed Independent Practitioner Signature: _____ Page# _____ Date: _____ Time: _____    Unit Secretary Signature: _____ Date: <u>10/18/16</u> Time: <u>0000</u> Registered Nurse Signature: <u>Alyson Passindri</u> <input type="checkbox"/> If verbal order, read back and verified by _____ RN							

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic orthographic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff

PLEASE NOTE!!!

DO NOT WRITE ON REVERSE SIDE OF THIS FORM.

**Mercy Fitzgerald Hospital**  
A member of Mercy Health System

BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO  
 DOB: 03/06/1979 37Y M  
 Adm: 10/7/2016  
 Acc: FA1307223089 MR#: F001250247



**PART III NURSING CARE**

(Nursing to Complete):

**A. Family Notification /Patient and Family Education:**Name of Family Member notified: Family not presentDate/Time: 10/18/16 0000☐ Pt. Refused  
☒ UnavailablePatient and family educated regarding reason for restraints and given hospital brochure.  
Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention &amp; use were identified on Interdisciplinary Plan of Care /Team Treatment Plan.

RN Initials: ARC**B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:**

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses &amp; good color, Skin Assessment &amp; Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

Behavioral Key:

1 = Threatening    2 = Combative    3 = Violent    4 = Assaultive    5 = Loud/Yelling    6 = Agitated  
 7 = Uncooperative    8 = Calmer    9 = Quiet    10 = Cooperative    11 = Medicated    12 = Ate (Describe)  
 13 = Drank (Describe)    14 = Other (See Comments)

Time every 15 min	Behavior Key	Circle Restrained Limbs	Comments/Observations/Interventions	Assigned Staff Observer Signature
0000	6,7	(R)(L)(RL)LL	Circv, T+R, Haldol IV given, Assessment	ARassindw
0015	6,7	(R)(L)(RL)LL	Circv, Ativan given as per CIWA, MC	ARassindw
0030	6	(R)(L)(RL)LL	Circv, VSS, RUM, Suctioned, Restless	ARassindw
0045	6	(R)(L)(RL)LL	Circv, SR, MC, Appears to hallucinate	ARassindw
0100	6,7	(R)(L)(RL)LL	Circv, Ativan as per CIWA, RUM	ARassindw
0115	6,7	(R)(L)(RL)LL	Circv, Restless, Tachypneic, Suctioned	ARassindw
0130	6	(R)(L)(RL)LL	Circv, MC, Suctioned, Easily agitated	ARassindw
0145	6	(R)(L)(RL)LL	Circv, RUM, MC, Pericare	ARassindw
0200	6,7	(R)(L)(RL)LL	Circv, RUM, T+R, Ativan as per CIWA	ARassindw
0215	6	(R)(L)(RL)LL	Circv, RUM, MC, VSS & RL Tachypnea	ARassindw
0230	6	(R)(L)(RL)LL	Circv, Suctioned, SR	ARassindw
0245	6	(R)(L)(RL)LL	Circv, MC, Pericare, SR	ARassindw
0300	6,7	(R)(L)(RL)LL	Circv, RUM, T+R, Ativan as per CIWA	ARassindw
0315	6	(R)(L)(RL)LL	Circv, MC, Hallucinations ↓	ARassindw
0330	6,7	(R)(L)(RL)LL	Circv, MC, RUM, Uncooperative	ARassindw

**C. Reassessment:** Nurse reassess the patient at the end of the time ordered or when released.Date: 10/18/16Time: 0400

Pt continues to be unreliable, impulsive + attempts to strike when limbs are released despite sedation.

☐ Continue Restraints    ☐ New order obtained    Signature/Title: \_\_\_\_\_

Vital Signs: Time \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_ BP. \_\_\_\_\_ / \_\_\_\_\_

**D. Restraints Discontinued:** The patient has met the following criteria for restraint removal or release from locked seclusion:Criteria for Removal ☒ as appropriate, complete when released

☐ Increased behavioral control    ☐ No assaultive threats    ☐ Demonstrates calm behavior    ☐ Improved mental status    ☐ Improved communication    ☐ Other \_\_\_\_\_  
☐ Decreased agitation    ☐ No threats of self harm    ☐ Follows directions    ☐ Interacts with staff    ☐ Agrees to Safety Contract

Signature/Title: \_\_\_\_\_ Date Ended: \_\_\_\_\_ Time Ended: \_\_\_\_\_ AM/PM

**E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form** ☐ Yes ☐ No**F. ☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.**Total Time Restrained: 4 Hours \_\_\_\_\_ Minutes

 **Mercy Fitzgerald Hospital**  
A member of Mercy Health System

BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247









**PART III NURSING CARE**

(Nursing to Complete):

**A. Family Notification / Patient and Family Education:**Name of Family Member notified: Alf error alDate/Time: 10/18/16 0400☐ Pt. Refused☒ Unavailable

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention &amp; use were identified on Interdisciplinary Plan of Care / Team Treatment Plan.

RN Initials: AL**B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:**

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses &amp; good color, Skin Assessment &amp; Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

**Behavioral Key:**

1 = Threatening 2 = Combative 3 = Violent 4 = Assaultive 5 = Loud/Yelling 6 = Agitated

7 = Uncooperative 8 = Calmer 9 = Quiet 10 = Cooperative 11 = Medicated 12 = Ate (Describe)

13 = Drank (Describe) 14 = Other (See Comments)

Time every 15 min.	Behavior Key	Circle Restrained Limbs	Comments/Observations/Interventions	Assigned Staff Observer Signature
0400	6,7	RA LA RL LL	Circ ✓, ROM, T+R, MC. Suctioned	Alf error al
0415	6,7	RA LA RL LL	Circ ✓, Assessment, Advise as per CIWA	Alf error al
0430	8	RA LA RL LL	Circ ✓, ROM, MC	Alf error al
0445	8	RA LA RL LL	Circ ✓, T+R, Back care, MC	Alf error al
0500	8	RA LA RL LL	removed dc'd	Alf error al
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		

**C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.**Date: 10/18/16Time: 0500Removed due to ↓ aggression. Changed to 2 pt soft wrists☐ Continue Restraints☐ New order obtained

Signature/Title: \_\_\_\_\_

Vital Signs: Time \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_ BP. \_\_\_\_\_ / \_\_\_\_\_

**D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:**Criteria for Removal ☒ as appropriate, complete when released☒ Increased behavioral control ☒ No assaultive threats ☐ Demonstrates calm behavior ☐ Improved mental status ☐ Improved communication ☐ Other \_\_\_\_\_☒ Decreased agitation ☒ No threats of self harm ☒ Follows directions ☐ Interacts with staff ☐ Agrees to Safety ContractSignature/Title: Alf error al Date Ended: 10/18/16 Time Ended: 0500 AM/PME. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form ☐ Yes ☐ NoF. ☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.Total Time Restrained: 1 Hours 0 MinutesMercy Fitzgerald Hospital  
A member of Mercy Health System

BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247





PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b> THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED Age: _____ Gender: _____ Care Unit: _____ Shift: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS					
DATE	TIME	FAXED	ORDERS		
1	10/13	2300	<div style="text-align: center;"> <b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b>            Restraint Assessment and Physician Order  <input type="checkbox"/> Initial Assessment    <input type="checkbox"/> Reassessment         </div> <div> <b>(Nursing to Complete):</b>  <b>A. Nursing Assessment:</b>            Describe current behavior:  <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings  <input type="checkbox"/> Other _____         </div> <div> <b>B. Alternatives Tried</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Companionship: family, friend volunteer  <input type="checkbox"/> Skin Sleeve  <input checked="" type="checkbox"/> Increased checks and observation  <input type="checkbox"/> Bed alarm  <input type="checkbox"/> Medication  <input type="checkbox"/> Diversion/Activity/Busy Box  <input type="checkbox"/> Positioning Pillows  <input type="checkbox"/> Other: _____           </div> <div> <input type="checkbox"/> Decrease Stimuli/Noise Reduction  <input type="checkbox"/> Modify environment  <input type="checkbox"/> Close Observation  <input type="checkbox"/> Toileting/Hydration (q 2 hours while awake)  <input type="checkbox"/> Reviewed/Assessed Medications and Lab values  <input type="checkbox"/> Assessed for underlying problem  <input type="checkbox"/> Assistance with toileting           </div> </div> </div> <div>           RN Signature: <u><i>V. Alimatah</i></u>    Date: <u>10/13</u>    Time: <u>2300</u> </div>		
2			<b>PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.		
3			<b>B. Time:</b> APPLY FROM (TIME) <u>2300</u> AM/PM TO (TIME) <u>2300</u> AM/PM - 24 HOUR MAXIMUM		
4			<b>C. Type of restraint:</b> <input checked="" type="checkbox"/> Soft Liner <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Geri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Siderails		
5			<b>D. <input checked="" type="checkbox"/> Attending physician notified of restraint</b>		
6			<b>E. Signatures:</b> Date: <u>10/13</u> Time: <u>2300</u> Physician <u><i>[Signature]</i></u> Date: <u>10/13</u> Time: <u>2300</u> Nurse Signature and title <u><i>V. Alimatah</i></u> Beeper# _____ Date: _____ Time: _____ Unit Secretary Signature _____		

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff.

PLEASE NOTE!!!

DO NOT WRITE ON REVERSE SIDE OF THIS FORM.

**Mercy Fitzgerald Hospital**  
A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089

MR#: F001250247

IASM.X.OTHERFI





## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following Instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: as abovePlan of care Implemented as above: Nurse's Signature: [Signature]

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
2300	5	AD	(RA) (LA) RL LL	T+R.	<u>[Signature]</u>
0100	6	AD	(RA) (LA) RL LL	questioned	<u>[Signature]</u>
0300	10	AD	(RA) (LA) RL LL	T+R	<u>[Signature]</u>
0500	5	AD	(RA) (LA) RL LL	A.M. Care	<u>[Signature]</u>
0700	6	AD	(RA) (LA) RL LL	T+R	<u>[Signature]</u>
0900	5	AD	(RA) (LA) RL LL	Assess (P) P/T F/U M/R C/L S/D/D	<u>[Signature]</u>
1100	5	AD	(RA) (LA) RL LL	Assess B/L M/R C/L F/U T/F S/D/D	<u>[Signature]</u>
1226	5	AD	(RA) (LA) RL LL	A/C P/T F/U M/R C/L S/D/D	<u>[Signature]</u>
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/14/16 Time: 9H  
☐ Continue Restraints as warranted by patient's condition as assessed and documented

Nurse's Signature: [Signature]

Evening/PM Shift: Date: \_\_\_\_\_ Time: \_\_\_\_\_  
☐ Continue Restraints as warranted by patient's condition as assessed and documented

Nurse's Signature: \_\_\_\_\_

Night/PM Shift: Date: 10/14/16 Time: 0100  
☒ Continue Restraints as warranted by patient's condition as assessed and documented

Nurse's Signature: [Signature]D. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)

☐ Removal of lines/tubes/dressings    ☐ Ability to follow instructions - not pulling on lines/tubes/catheters/drains  
 Date: 10/14/16 Time of Restraint Release: 1226 Nurse's Signature: [Signature]

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

Mercy Fitzgerald Hospital  
 A member of Mercy Health System

RESTRAINTS (NON-VIOLENT)

BFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



1ASM.X.OTHERF1

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b> THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED. Age: _____ Gender: _____ Care Unit: _____ Shift: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS					
DATE	TIME	FAXED	ORDERS		
1			RESTRAINTS FOR NON-VIOLENT BEHAVIOR Restraint Assessment and Physician Order <input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment		
2			(Nursing to Complete): A. Nursing Assessment: Describe current behavior: <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings <input type="checkbox"/> Other _____		
3			B. Alternatives Tried <input checked="" type="checkbox"/> Companionship: family, friend volunteer <input checked="" type="checkbox"/> Decrease Stimuli/Noise Reduction <input type="checkbox"/> Skin Sleeve <input checked="" type="checkbox"/> Modify environment <input checked="" type="checkbox"/> Increased checks and observation <input checked="" type="checkbox"/> Close Observation <input checked="" type="checkbox"/> Bed alarm <input type="checkbox"/> Toileting/Hydration (q 2 hours while awake) <input type="checkbox"/> Medication <input type="checkbox"/> Reviewed/Assessed Medications and Lab values <input type="checkbox"/> Diversion/Activity/Busy Box <input checked="" type="checkbox"/> Assessed for underlying problem <input checked="" type="checkbox"/> Positioning Pillows <input type="checkbox"/> Assistance with toileting <input type="checkbox"/> Other _____		
4			RN Signature: <u>Devin McCann</u> Date: <u>10/14/16</u> Time: <u>2000</u>		
5			PHYSICIAN ORDERS (Physician to Complete): A. Clinical Justification: <input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.		
6			B. Time: APPLY FROM (TIME) <u>2000</u> AM/PM TO (TIME) <u>2000</u> AM/PM - 24 HOUR MAXIMUM		
7			C. Type of restraint: <input checked="" type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Gerri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Sideralls		
8			D. <input type="checkbox"/> Attending physician notified of restraint		
9			E. Signatures: Date: <u>10/14/16</u> Time: <u>2000</u> Physician: <u>[Signature]</u> Date: <u>10/14/16</u> Time: <u>2000</u> Nurse Signature and title: <u>Devin McCann</u> Date: _____ Time: _____ Unit Secretary Signature: _____		

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff.

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RESTRAINTS (NON-VIOLENT)

1 ASM.X.OTHERF1

Page 1 of 2  
Form #PH719, Rev. 01/2008  
ASM.X.OTHER

EFUNNUGA, OLUTOKUNBO-  
DOB: 03/06/1979 37Y M  
Adm: 10/7/2016  
Acc: FA1307223089 MR#: F001250247



## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed  
 Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: \_\_\_\_\_

Plan of care implemented as above: \_\_\_\_\_

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
2000	1	AD	(RA) (LA) RL LL	repositioned ROM	DMC [Signature]
2200	6	AD	(RA) (LA) RL LL	on call	DMC [Signature]
0000	5	AD	(RA) (LA) RL LL	MC on ROM	DMC [Signature]
0200	7	AD	(RA) (LA) RL LL	repositioned ROM	DMC [Signature]
0400	10	AD	(RA) (LA) RL LL	Bathed & repositioned	DMC [Signature]
0600	10	AD	(RA) (LA) RL LL	MC on ROM	DMC [Signature]
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: \_\_\_\_\_ Time: \_\_\_\_\_

☐ Continue Restraints as warranted by patient's condition as assessed and documented

Nurses Signature \_\_\_\_\_

Evening/PM Shift: Date: \_\_\_\_\_ Time: \_\_\_\_\_

☐ Continue Restraints as warranted by patient's condition as assessed and documented

Nurses Signature \_\_\_\_\_

Night/PM Shift: Date: 10/15/16 Time: 2100

☒ Continue Restraints as warranted by patient's condition as assessed and documented

Nurses Signature \_\_\_\_\_

D. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)

☐ Removal of Lines/Tubes/dressings      ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/Drains

Date \_\_\_\_\_ Time of Restraint Release \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



1ASM.X.OTHERF1



PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b>	
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED	
				Age: _____ Gender: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS				Care Unit: _____ Shift: _____	

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY
1			<div style="text-align: center;"> <b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b>            Restraint Assessment and Physician Order  <input type="checkbox"/> Initial Assessment    <input checked="" type="checkbox"/> Reassessment         </div> <div> <b>(Nursing to Complete):</b>  <b>A. Nursing Assessment:</b>            Describe current behavior:  <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings  <input checked="" type="checkbox"/> Other <u>suicide precautions 302'd</u> </div> <div> <b>B. Alternatives Tried</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Companionship: family, friend volunteer  <input checked="" type="checkbox"/> Skin Sleeve  <input checked="" type="checkbox"/> Increased checks and observation  <input checked="" type="checkbox"/> Bed alarm  <input checked="" type="checkbox"/> Medication  <input type="checkbox"/> Diversion/Activity/Busy Box  <input checked="" type="checkbox"/> Positioning Pillows  <input checked="" type="checkbox"/> Other: <u>1:1 Supervision</u> </div> <div> <input checked="" type="checkbox"/> Decrease Stimuli/Noise Reduction  <input checked="" type="checkbox"/> Modify environment  <input checked="" type="checkbox"/> Close Observation  <input checked="" type="checkbox"/> Toileting/Hydration (q 2 hours while awake)  <input checked="" type="checkbox"/> Reviewed/Assessed Medications and Lab values  <input checked="" type="checkbox"/> Assessed for underlying problem  <input checked="" type="checkbox"/> Assistance with toileting           </div> </div> </div> <div>           RN Signature: <u>A. Kassirer</u>    Date: <u>10/18/16</u>    Time: <u>0500</u> </div> <div> <b>PHYSICIAN ORDERS (Physician to Complete):</b>  <b>A. Clinical Justification:</b>  <input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.         </div> <div> <b>B. Time:</b>            APPLY FROM (TIME) <u>0500</u> AM/PM TO (TIME) <u>0500</u> AM/PM - 24 HOUR MAXIMUM         </div> <div> <b>C. Type of restraint:</b>  <input checked="" type="checkbox"/> Soft Limb:    <input type="checkbox"/> 1 Point    <input checked="" type="checkbox"/> 2 Point    <input type="checkbox"/> 3 Point  <input type="checkbox"/> Gerri Chair with Tray  <input type="checkbox"/> Peek-a-boo Mitts  <input checked="" type="checkbox"/> 3-4 Siderails         </div> <div> <b>D. <input checked="" type="checkbox"/> Attending physician notified of restraint</b> </div> <div> <b>E. Signatures:</b>            Date: <u>10/16</u> Time: <u>0500</u> Physician <u>Milosh Kumar</u>            Date: <u>10/18</u> Time: <u>0500</u> Nurse Signature and title <u>Alyson Kassirer</u>    Beep# _____            Date: _____ Time: _____ Unit Secretary Signature _____         </div>	

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERFI



## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: See Section BPlan of care implemented as above: Nurse's Signature A. Rasmussen

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
0500	2,4	A,D	(RA) (LA) RL LL	Circ, ROM, Bath done	A. Rasmussen
0700	2,4,6	A,D	(RA) (LA) RL LL	Circ, ROM, MC, T+R	A. Rasmussen
0900	7,10	A,D	(RA) (LA) RL LL	Assessed ROM, MC, T+R	A. Rasmussen
1100	7,10	A,D	(RA) (LA) RL LL	MC	A. Rasmussen
1300	7,10	A,D	(RA) (LA) RL LL	MC	A. Rasmussen
1500	10	A,D	(RA) (LA) RL LL	MC	A. Rasmussen
1700	10	A,D	(RA) (LA) RL LL	MC	A. Rasmussen
1900	5	A,D	(RA) (LA) RL LL	ROM, Circ, T+R	A. Rasmussen
2100	6	A,D	(RA) (LA) RL LL	ROM, Circ, T+R	A. Rasmussen
2300	6	A,D	(RA) (LA) RL LL	Circ, ROM, T+R, Bed change	A. Rasmussen
0100	6	A,D	(RA) (LA) RL LL	Circ, ROM, Assessment T+R	A. Rasmussen
0300	1,5	A,D	(RA) (LA) RL LL	Circ ROM, PM Care T+R, MC	A. Rasmussen
0500	6	A,D	(RA) (LA) RL LL	Circ ROM T+R, Bathed MC	A. Rasmussen
0700	2,3,4	A,D	(RA) (LA) RL LL	Circ, ROM, T+R, MC	A. Rasmussen

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/18/16 Time: 0800☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature A. RasmussenEvening/PM Shift: Date: 10/18/16 Time: 1900☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature A. RasmussenNight/PM Shift: Date: 10/19/16 Time: 0000☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature A. RasmussenD. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/Drains

Date \_\_\_\_\_ Time of Restraint Release \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERFI

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b> THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED Age: <u>37</u> Gender: <u>Male</u> Care Unit: <u>ICU</u> Shift: <u>7P-7A</u>	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS					
DATE	TIME	FAXED	ORDERS		
			<b>BEHAVIORAL RESTRAINT ASSESSMENT FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR</b>		
			<b>PART I</b> <input type="checkbox"/> Initial Assessment <input type="checkbox"/> Reassessment (Nursing to Complete): <b>A. Nursing Assessment:</b>		
			<input type="checkbox"/> Severe Agitation <input type="checkbox"/> Assaultive/ Risk of Injury <input type="checkbox"/> Combative/Striking Out <input type="checkbox"/> Violent/ Aggressive Behavior <input type="checkbox"/> Self-Abusive <input type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis <input type="checkbox"/> Suicidal <input type="checkbox"/> Persistent aggressive verbal threats <input type="checkbox"/> Throwing Objects <input type="checkbox"/> Hitting/ Kicking/ Biting <input type="checkbox"/> Damaging Property <input type="checkbox"/> Behavior Dangerous to Self or Others <input type="checkbox"/> Self-Mutilating <input type="checkbox"/> Other: _____		
			<b>B. Identify the less-restrictive alternatives tried in order to modify behaviors:</b> <input type="checkbox"/> De-escalation <input type="checkbox"/> Calming Medication <input type="checkbox"/> 1:1 Observation <input type="checkbox"/> Set Clear, Firm Limits <input type="checkbox"/> PEAT Code <input type="checkbox"/> Family Members <input type="checkbox"/> Diversion/Activity <input type="checkbox"/> Quiet Room / Time-Out <input type="checkbox"/> Active Listening <input type="checkbox"/> Allow to Ventilate <input type="checkbox"/> Minimum Stimulation <input type="checkbox"/> Offer Alternatives / Choices <input type="checkbox"/> Other/Describe: _____		
			<b>C. Patient's Response to Above Alternatives:</b> _____ _____ _____		
			The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions.		
			RN Signature: _____ Date: _____ Time: _____		
			<b>PART II PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input type="checkbox"/> Imminent danger of harm to self or others <input type="checkbox"/> Combative/ Assaultive/ Violent behavior <input type="checkbox"/> Other: _____		
			<b>B. Time:</b> Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) _____ AM/PM TO (TIME) _____ AM/PM		
			<b>C. Type of restraint:</b> <input type="checkbox"/> Locked Seclusion (Psychiatric Units Only) <input type="checkbox"/> 3-4 Side rails <input type="checkbox"/> Locked Velcro Restraints <input type="checkbox"/> 4 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> 2 Point <input type="checkbox"/> Soft Limb <input type="checkbox"/> 4 Point <input type="checkbox"/> Other		
			<b>D. Continuous observation face-to-face by assigned staff for duration of episode.</b> Note: Face-to-face LIP / Physician visit must be completed within one hour and progress note written.		
			<b>E. Signatures:</b> Date: _____ Time: _____ Signature: _____ Pager# _____ Date: <u>5-11-18</u> Time: <u>0215</u> Unit Secretary Signature: _____ Date: <u>5-11-18</u> Time: <u>"</u> Registered Nurse Signature: <u>M. Walker</u> <input type="checkbox"/> If verbal order, read back and verified by _____ RN		

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BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO  
 DOB: 03/06/1979 37 M  
 ADM: 10/07/16  
 ACC: FA1307223089 MR: F001250247





**PART III NURSING CARE**

(Nursing to Complete):

**A. Family Notification /Patient and Family Education:**Name of Family Member notified: Kiki sisterDate/Time: 10-15-16☐ Pt. Refused  
☐ Unavailable

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention &amp; use were identified on Interdisciplinary Plan of Care /Team Treatment Plan.

RN Initials: NY**B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:**

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses &amp; good color, Skin Assessment &amp; Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

Behavioral Key:

1 = Threatening    2 = Combative    3 = Violent    4 = Assaultive    5 = Loud/Yelling    6 = Agitated  
 7 = Uncooperative    8 = Calmer    9 = Quiet    10 = Cooperative    11 = Medicated    12 = Ate (Describe)  
 13 = Drank (Describe)    14 = Other (See Comments)

Time every 15 min	Behavior Key	Circle Restrained Limbs	Comments/Observations/Interventions	Assigned Staff Observer Signature
0000	8	RA LA RI LI	Resting VSS	Nkeawaka
0015	8	RA LA RI LI	Medicated Repositioned	Nkeawaka
0030	9	RA LA RI LI	Resting VSS	Nkeawaka
0045	9	RA LA RI LI	Resting VSS	Nkeawaka
0100	9	RA LA RI LI	Resting VSS	Nkeawaka
0115	9	RA LA RI LI	Resting VSS	Nkeawaka
0130	9	RA LA RI LI	Mouthcare, Rin	Nkeawaka
0145	9	RA LA RI LI	Resting VSS	Nkeawaka
0200	9	RA LA RI LI	Resting VSS	Nkeawaka
0215	9	RA LA RI LI	Resting VSS	Nkeawaka
0230	9	RA LA RI LI	Resting VSS	Nkeawaka
0245	9	RA LA RI LI	Resting VSS	Nkeawaka
0300	9	RA LA RI LI	Resting VSS continued	Nkeawaka
0315	9	RA LA RI LI	Resting VSS	Nkeawaka
0330	9	RA LA RI LI	Resting VSS	Nkeawaka

**C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.**Date: 10-16-16Time: 0330Resting VSS☒ Continue Restraints☐ New order obtained

Signature/Title: \_\_\_\_\_

Vital Signs: Time \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_ BP. \_\_\_\_\_

**D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:**Criteria for Removal ☒ as appropriate, complete when released

☐ Increased behavioral control    ☐ No assaultive threats    ☐ Demonstrates calm behavior    ☐ Improved mental status    ☐ Improved communication    ☐ Other \_\_\_\_\_  
☐ Decreased agitation    ☐ No threats of self harm    ☐ Follows directions    ☐ Interacts with staff    ☐ Agrees to Safety Contract

Signature/Title: \_\_\_\_\_ Date Ended: \_\_\_\_\_ Time Ended: \_\_\_\_\_ AM/PM

**E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form**☐ Yes ☐ No**F. ☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.**

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

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BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37 M

ADM: 10/07/16

ACC: FA1307223089 MR: F001250247



PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO	DESCRIPTION OF EVENT
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS	

## PHYSICIAN ORDERS SHEET

THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED

 Age: 37 Gender: Male  
 Care Unit: ICU Shift: TP-7A

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY
1			<b>PART I BEHAVIORAL RESTRAINT ASSESSMENT FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR</b> <input checked="" type="checkbox"/> Initial Assessment <input type="checkbox"/> Reassessment <b>(Nursing to Complete):</b> <b>A. Nursing Assessment:</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Severe Agitation  <input type="checkbox"/> Combative/Stinking Out  <input type="checkbox"/> Self-Abusive  <input checked="" type="checkbox"/> Suicidal  <input type="checkbox"/> Throwing Objects  <input type="checkbox"/> Damaging Property  <input type="checkbox"/> Self-Mutilating           </div> <div> <input type="checkbox"/> Assaultive/ Risk of Injury  <input checked="" type="checkbox"/> Violent/ Aggressive Behavior  <input type="checkbox"/> Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis  <input type="checkbox"/> Persistent aggressive verbal threats  <input type="checkbox"/> Hitting/ Kicking/ Biting  <input type="checkbox"/> Behavior Dangerous to Self or Others  <input type="checkbox"/> Other: _____           </div> </div>	
2			<b>B. Identify the less-restrictive alternatives tried in order to modify behaviors:</b> <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> De-escalation  <input type="checkbox"/> PEAT Code  <input type="checkbox"/> Active Listening  <input type="checkbox"/> Other/Describe: _____           </div> <div> <input type="checkbox"/> Calming Medication  <input type="checkbox"/> Family Members  <input type="checkbox"/> Allow to Ventilate           </div> <div> <input type="checkbox"/> 1:1 Observation  <input type="checkbox"/> Diversion/Activity  <input type="checkbox"/> Minimum Stimulation           </div> <div> <input type="checkbox"/> Set Clear, Firm Limits  <input type="checkbox"/> Quiet Room / Time-Out  <input type="checkbox"/> Offer Alternatives / Choices           </div> </div>	
3			<b>C. Patient's Response to Above Alternatives:</b> _____ _____ _____	
4			The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>[Signature]</u> Date: <u>10-16-16</u> Time: <u>2015</u>	
5			<b>PART II PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input type="checkbox"/> Imminent danger of harm to self or others <input checked="" type="checkbox"/> Combative/ Assaultive/ Violent behavior <input type="checkbox"/> Other: _____	
6			<b>B. Time:</b> Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>2015</u> AM/PM TO (TIME) <u>2015</u> AM/PM C. Type of restraint: <u>10-16-16</u> <u>10-17-16</u>	
7			<input type="checkbox"/> Locked Seclusion (Psychiatric Units Only) <input type="checkbox"/> 3-4 Side rails <input checked="" type="checkbox"/> Locked Velcro Restraints <input type="checkbox"/> 4 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> 2 Point <input type="checkbox"/> Soft Limb <input checked="" type="checkbox"/> 4 Point <input type="checkbox"/> Other	
8			<b>D. Continuous observation face-to-face by assigned staff for duration of episode.</b> Note: Face-to-face LIP / Physician visit must be completed within one hour and progress note written.	
9			<b>E. Signatures:</b> Licensed Independent Practitioner Date: _____ Time: _____ Signature: <u>[Signature]</u> Pager# _____ Date: _____ Time: _____ Unit Secretary Signature _____ Date: <u>10-16-16</u> Time: <u>2015</u> Registered Nurse Signature: <u>[Signature]</u> <input type="checkbox"/> If verbal order, read back and verified by _____ RN	

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BEHAVIORAL RESTRAINTS (VIOLENT)

 EFUNNUGA, OLUTOKUNBO  
 DOB: 03/06/1979 37 M  
 ADM: 10/07/16  
 ACC: FA1307223089 MR: F001250247




**PART III NURSING CARE**

(Nursing to Complete):

**A. Family Notification / Patient and Family Education:**Name of Family Member notified: pt's sisterDate/Time: 10-16-16☐ Pt. Refused  
☐ Unavailable

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention &amp; use were identified on Interdisciplinary Plan of Care / Team Treatment Plan.

RN Initials: NR**B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:**

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses &amp; good color, Skin Assessment &amp; Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

Behavioral Key:

1 = Threatening    2 = Combative    3 = Violent    4 = Assaultive    5 = Loud/Yelling    6 = Agitated  
 7 = Uncooperative    8 = Calmer    9 = Quiet    10 = Cooperative    11 = Medicated    12 = Ate (Describe)  
 13 = Drank (Describe)    14 = Other (See Comments)

Time every 15 min	Behavior Key	Circle Restrained Limbs	Comments/Observations/Interventions	Assigned Staff Observer Signature
2015	5,6	(R) (A) (R) (L)	CELT code, security called	Nkwakwa
2030	6	(R) (A) (R) (L)	Back in bed, 4pt total restraints	Nkwakwa
2045	6	(R) (A) (R) (L)	Medication given	Nkwakwa
2100	6	(R) (A) (R) (L)	Restless close monitoring	Nkwakwa
2115	9	(R) (A) (R) (L)	Asleeping, VSS, 1:1	Nkwakwa
2130	9	(R) (A) (R) (L)	Asleeping VSS 1:1	Nkwakwa
2145	9	(R) (A) (R) (L)	Asleeping VSS	Nkwakwa
2200	9	(R) (A) (R) (L)	Asleeping VSS	Nkwakwa
2215	9	(R) (A) (R) (L)	Asleeping VSS	Nkwakwa
2230	7	(R) (A) (R) (L)	Asleeping PM care given	Nkwakwa
2245	7	(R) (A) (R) (L)	Asleeping ROM	Nkwakwa
2300	7	(R) (A) (R) (L)	Asleeping ROM	Nkwakwa
2315	7	(R) (A) (R) (L)	Asleeping ROM	Nkwakwa
2330	7	(R) (A) (R) (L)	Asleeping ROM	Nkwakwa
2345	7	(R) (A) (R) (L)	Asleeping ROM	Nkwakwa

**C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.**Date: 10-16-16Time: 2345Asleeping in DT's bed, medication given☒ Continue Restraints☐ New order obtainedSignature/Title: Nkwakwa

Vital Signs: Time \_\_\_\_\_ T. \_\_\_\_\_ P. \_\_\_\_\_ R. \_\_\_\_\_ BP. \_\_\_\_\_

**D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:**Criteria for Removal ☒ as appropriate, complete when released

☐ Increased behavioral control    ☐ No assaultive threats    ☐ Demonstrates calm behavior    ☐ Improved mental status    ☐ Improved communication    ☐ Other \_\_\_\_\_  
☐ Decreased agitation    ☐ No threats of self harm    ☐ Follows directions    ☐ Interacts with staff    ☐ Agrees to Safety Contract

Signature/Title: \_\_\_\_\_ Date Ended: \_\_\_\_\_ Time Ended: \_\_\_\_\_ AM/PM

**E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form**☐ Yes ☐ No**F. ☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.**

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

**Mercy Fitzgerald Hospital**  
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BEHAVIORAL RESTRAINTS (VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37 M

ADM: 10/07/16

ACC: FA1307223089 MR: F001250247



PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		<b>PHYSICIAN ORDERS SHEET</b> THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED Age: _____ Gender: _____ Care Unit: _____ Shift: _____	
<input type="checkbox"/> CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS					
	DATE	TIME	FAXED	ORDERS	
1				<b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b> Restraint Assessment and Physician Order <input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment	
2				<b>(Nursing to Complete):</b> <b>A. Nursing Assessment:</b> Describe current behavior: <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings <input type="checkbox"/> Other _____	
3				<b>B. Alternatives Tried</b>	
4				<input type="checkbox"/> Companionship: family, friend volunteer <input type="checkbox"/> Decrease Stimuli/Noise Reduction <input type="checkbox"/> Skin Sleeve <input type="checkbox"/> Modify environment <input type="checkbox"/> Increased checks and observation <input type="checkbox"/> Close Observation <input type="checkbox"/> Bed alarm <input type="checkbox"/> Toileting/Hydration (q 2 hours while awake) <input type="checkbox"/> Medication <input type="checkbox"/> Reviewed/Assessed Medications and Lab values <input type="checkbox"/> Diversion/Activity/Busy Box <input type="checkbox"/> Assessed for underlying problem <input type="checkbox"/> Positioning Pillows <input type="checkbox"/> Assistance with toileting <input type="checkbox"/> Other: _____	
5				RN Signature: <u>Guan C. J. J.</u> Date: <u>4/11/16</u> Time: <u>2200</u>	
6				<b>PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.	
7				<b>B. Time:</b> APPLY FROM (TIME) <u>2200</u> AM/PM TO (TIME) <u>2200</u> AM/PM - 24 HOUR MAXIMUM	
8				<b>C. Type of restraint:</b> <input checked="" type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2- Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Geri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Siderails	
9				<b>D. <input type="checkbox"/> Attending physician notified of restraint</b>	
10				<b>E. Signatures:</b>	
11				Date: _____ Time: _____ Physician <u>[Signature]</u>	
12				Date: <u>4/11/16</u> Time: <u>2200</u> Nurse Signature and title <u>[Signature]</u> Beeper# _____	
13				Date: _____ Time: _____ Unit Secretary Signature _____	
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

Unless written "Do Not Substitute" by the physician, approval is given that all pharmaceuticals ordered by the trade names may be dispensed with the generic or therapeutic alternate in stock as defined by the Mercy Health System's Pharmacy & Therapeutic Committee of the Medical Staff.

PLEASE NOTE!!!

DO NOT WRITE ON REVERSE SIDE OF THIS FORM.

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO 506  
 DOB: 03/06/1979 37Y  
 Adm: 10/7/2016  
 Acc: FA1307223089 MR#: F001250247





## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

## OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

## PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of Injury and skin integrity.

## ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

## Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

## Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other interventions: As abovePlan of care implemented as above: Nurse's Signature V. Valmala

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
320		A.D	(RA/LA) RL LL	TAH suction	<u>Shoung</u>
2400	10	A.D	(RA/LA) RL LL	TAH	<u>Valmala</u>
0200	5	B.D	(RA/LA) RL LL	suction	<u>Valmala</u>
0400	10	A.D	(RA/LA) RL LL	TAH care	<u>Valmala</u>
0600	10	A.D	(RA/LA) RL LL	TAH suction	<u>Valmala</u>
0800	10	A.D	(RA/LA) RL LL	TAH suction (DPP TF lines)	<u>Valmala</u>
10	10	A.D	(RA/LA) RL LL	TAH TF lines; DPP suction	<u>Valmala</u>
12	10	A.D	(RA/LA) RL LL	TAH TF lines; suction	<u>Valmala</u>
14	5	A.D	(RA/LA) RL LL	TAH TF lines; SW cath	<u>Valmala</u>
16	5	A.D	(RA/LA) RL LL	TAH TF lines; SW cath	<u>Valmala</u>
18	6	A.D	(RA/LA) RL LL	TAH TF lines; SW cath	<u>Valmala</u>
20	5	A.D	(RA/LA) RL LL	TAH TF lines; SW cath	<u>Valmala</u>
22	6	A.D	(RA/LA) RL LL	TAH TF lines; SW cath	<u>Valmala</u>
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/12/16 Time: 7A☐ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature LS/ValmalaEvening/PM Shift: Date: 10/12/16 Time: 1600☐ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature ValmalaNight/PM Shift: Date: 10/12/16 Time: 0700☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurses Signature ValmalaD. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/Drains

Date \_\_\_\_\_ Time of Restraint Release \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y

Adm: 10/7/2016

Acc: FA1307223089

MR#: F001250247

IASM.X.OTHERF





6

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:		DESCRIPTION OF EVENT		PHYSICIAN ORDERS SHEET		
				THIS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED		
				Age: _____ Gender: _____		
[ ] CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS				Care Unit: _____ Shift: _____		
DATE	TIME	FAXED	ORDERS			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23			<b>RESTRAINTS FOR NON-VIOLENT BEHAVIOR</b> <b>Restraint Assessment and Physician Order</b> <input type="checkbox"/> Initial Assessment <input checked="" type="checkbox"/> Reassessment			
			<b>(Nursing to Complete):</b> <b>A. Nursing Assessment:</b> Describe current behavior: <input checked="" type="checkbox"/> Pulling at Lines/Tubes/Catheters/Dressings <input type="checkbox"/> Other _____			
			<b>B. Alternatives Tried</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input checked="" type="checkbox"/> Companionship: family, friend volunteer  <input type="checkbox"/> Skin Sleeve  <input checked="" type="checkbox"/> Increased checks and observation  <input checked="" type="checkbox"/> Bed alarm  <input checked="" type="checkbox"/> Medication  <input checked="" type="checkbox"/> Diversion/Activity/Busy Box  <input checked="" type="checkbox"/> Positioning Pillows  <input type="checkbox"/> Other: _____ </div> <div style="width: 48%;"> <input checked="" type="checkbox"/> Decrease Stimuli/Noise Reduction  <input checked="" type="checkbox"/> Modify environment  <input checked="" type="checkbox"/> Close Observation  <input checked="" type="checkbox"/> Toileting/Hydration (q 2 hours while awake)  <input checked="" type="checkbox"/> Reviewed/Assessed Medications and Lab values  <input checked="" type="checkbox"/> Assessed for underlying problem  <input type="checkbox"/> Assistance with toileting </div> </div>			
	10/8/16	2000		RN Signature: <u><i>Daniel R. Duda</i></u> Date: <u>10/8/16</u> Time: <u>2000</u>		
				<b>PHYSICIAN ORDERS (Physician to Complete):</b> <b>A. Clinical Justification:</b> <input checked="" type="checkbox"/> To protect against removal of Lines/Tubes/Catheters/Dressings.		
				<b>B. Time:</b> APPLY FROM (TIME) <u>2000</u> AM/PM TO (TIME) <u>2000</u> AM/PM - 24 HOUR MAXIMUM		
				<b>C. Type of restraint:</b> <input checked="" type="checkbox"/> Soft Limb: <input type="checkbox"/> 1 Point <input checked="" type="checkbox"/> 2 Point <input type="checkbox"/> 3 Point <input type="checkbox"/> Gerri Chair with Tray <input type="checkbox"/> Peek-a-boo Mitts <input checked="" type="checkbox"/> 3-4 Siderails		
				<b>D. <input checked="" type="checkbox"/> Attending physician notified of restraint</b>		
				<b>E. Signatures:</b> Date: <u>10/8</u> Time: <u>2000</u> Physician: <u><i>Vishesh Kumar</i></u>		
				Date: <u>10/8</u> Time: <u>2000</u> Nurse Signature and title: <u><i>Daniel R. Duda</i></u> Beep# _____		
				Date: _____     Time: _____     Unit Secretary Signature: _____		

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO  
DOB: 03/06/1979 37Y M  
Adm: 10/7/2016  
Acc: FA1307223089 MR#: F001250247



1 ASM.X.OTHERF1

## A. (Nursing to Complete):

- ☒ Family notified of restraint  
☒ Patient/family educated regarding reason for restraint  
☒ Restraint prevention and use identified on care plan

## B. RESTRAINT PLAN OF CARE FOR NON-VIOLENT BEHAVIOR

OBSERVE AND INTERACT WITH PATIENT AND PROVIDE PHYSICAL CARE,

Check circulation in limbs - For the presence of pulses and good color - Provide every 2 hours and more frequently if needed

Range-of-motion exercises and restraint release of all limbs one at a time - Provide every 2 hours and more frequently if needed

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed

PROVIDE SAFETY AND COMFORT MEASURES,

Assess for signs of injury and skin integrity.

ASSESS BEHAVIOR AND RESPONSE TO RESTRAINTS.

Assess readiness for release

Assess Behavior and enter number key that best describes behavior:

Behavioral Key:

- 1 = Agitated      2 = Confused      3 = Uncooperative      4 = Forgetful      5 = Restless  
 6 = Calmer      7 = Sleeping      8 = Following instructions      10 = resting

Type of Restraint Code:

- A. Soft Limb      B. Geri chair with tray      C. Peek-a-boo Mitts      D. 3-4 Siderails

Other Interventions: See page 1 section BPlan of care implemented as above: Nurse's Signature Daniel M. Duffin

Time every 2 Hours	Behavior Key	Type Code	Circle Limb/s Restrained	Comments/Observations/Interventions	Assigned Staff Observer Signature
2000	9, 10	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
0000	4, 10	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
0200	4, 10	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
0400	7, 10	AS	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
0600	2, 10	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
0800	7, 10	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
1000	7	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
1200	7	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
1400	7	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
1600	7	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
1800	1, 5	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
2000	7, 10	AD	RA LA RL LL	RRM, T&R, @Pulse, circ V	Daniel M. Duffin RA
			RA LA RL LL		
			RA LA RL LL		
			RA LA RL LL		

## C. Reassessment: NURSES REASSESSES EVERY SHIFT AND DOCUMENTS BELOW:

Date/AM Shift: Date: 10/9/16 Time: 1800☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature M. BroughtonEvening/PM Shift: Date: 10/9/16 Time: 1900☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature Daniel M. DuffinNight/PM Shift: Date: 10/9/16 Time: 0000☒ Continue Restraints as warranted by patient's condition as assessed and documentedNurse's Signature Daniel M. DuffinD. RESTRAINTS DISCONTINUATION: patient meets criteria for removal: ( ☒ as appropriate)☐ Removal of Lines/Tubes/dressings ☐ Ability to follow instructions - not pulling on Lines/Tubes/Catheters/Drains

Date \_\_\_\_\_ Time of Restraint Release \_\_\_\_\_ Nurse's Signature \_\_\_\_\_

Total Time Restrained: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes \_\_\_\_\_

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RESTRAINTS (NON-VIOLENT)

EFUNNUGA, OLUTOKUNBO

DOB: 03/06/1979 37Y M

Adm: 10/7/2016

Acc: FA1307223089 MR#: F001250247



IASM.X.OTHERFI

**Patient Instructions Signature Page**

Patient Name: EFUNNUGA, OLUTOKUNBO  
Account Number: FA1307223089  
Date of Birth: Mar 6, 1979

Guardian Name: MOBLEY, SHEREE

The above-named patient and/or guardian has received the following:  
Patient Visit Report

Patient Instructions  
Aspiration Pneumonia (DC)

RXM Orders

Signature Disclaimer  
Please make sure you have read through this information before signing.


**I have read and understand the instructions given to me by my caregivers.**

 11/11/17  
-----  
Print Patient Name

-----  
Patient (or Guardian) Signature

Date

Time



11/1/16

16:00

-----  
Caregiver/RN/Doctor Signature

Date

Time



DATE: 11/11/16 @ 0049  
USER: MT

Mercy Fitzgerald Hospital AOM \*LIVE\*  
Ambulatory Prescriptions and Procedures

PAGE 1

Patient Name: EFUNNUGA, OLUTOKUNBO      Admission/Registration Date: 10/07/16  
Unit Number: F001250247      Discharge Date: 11/01/16  
Account Number: FA1307223089      Admitting Physician: LITTMAN, MARIO, MD  
Date of Birth: 03/06/1979      Age/Sex: 37 M      Attending Physician: LITTMAN, MARIO, MD

Preferred Pharmacy: RITE AID-950 E BALTIMORE PK 950 EAST BALTIMORE PIKE YEADON, PA 19  
Phone: (610)622-3795 Fax: (610)622-4500  
Mail Order: N LTC: N Specialty: N 24Hrs: N eRx: Y EPCS: Y

### Prescriptions

Clotrimazole (Clotrimazole) 10 Mg Troche  
10 MG MUCOUS MEM 5 TIMES DAILY 28 Days  
Rx# 0000000183      Days: 28      Refills: 0  
Entered Date: Oct 31, 2016      Compound Med: No  
Ordering Provider: JADHGA      Location: FI4PVA  
Diagnosis:

Latanoprost (Latanoprost) 2.5 Ml Drops  
1 DROP BOTH EYES EVERY EVENING 28 Days  
Rx# 0000000184      Days: 28      Refills: 0      DROPS  
Entered Date: Oct 31, 2016      Compound Med: No  
Instructions: 2.5 ML  
Ordering Provider: JADHGA      Location: FI4PVA  
Diagnosis:

Metoprolol Tartrate (Metoprolol Tartrate) 25 Mg Tablet  
6.25 MG ORAL EVERY 12 HOURS 30 Days  
Rx# 0000001015      Days: 30      Refills: 0      TABLET  
Entered Date: Nov 1, 2016      Compound Med: No  
Ordering Provider: SHETVI      Location: FI4PVA  
Diagnosis:

Thera (Multivitamin, Therapeutic) 1 Tab Tablet  
1 TAB ORAL DAILY 30 Days  
Rx# 0000001016      Days: 30      Refills: 0      TABLET  
Entered Date: Nov 1, 2016      Compound Med: No  
Ordering Provider: SHETVI      Location: FI4PVA  
Diagnosis:

Vitamin B-1 (Thiamine HCl) 100 Mg Tablet  
100 MG ORAL DAILY 30 Days  
Rx# 0000001017      Days: 30      Refills: 0      TABLET  
Entered Date: Nov 1, 2016      Compound Med: No  
Ordering Provider: SHETVI      Location: FI4PVA  
Diagnosis:

traMADol HCl (traMADol HCl) 50 Mg Tablet  
50 MG ORAL EVERY 4 HOURS As needed for SEVERE PAIN 20 Days  
Rx# 0000001018      Days: 20      Refills: 0      TABLET  
Entered Date: Nov 1, 2016      Compound Med: No  
Control Schedule: 4  
Ordering Provider: SHETVI      Location: FI4PVA  
Diagnosis:



DATE: 11/11/16 @ 0049  
USER: MT

Mercy Fitzgerald Hospital AOM \*LIVE\*  
Ambulatory Prescriptions and Procedures

PAGE 2

Patient Name: EFUNNUGA OLUTOKUNBO

Admission/Registration Date: 10/07/16

Unit Number: F001250247

Discharge Date: 11/01/16

Account Number: FA1307223089

Admitting Physician: LITTMAN, MARIO, MD

Date of Birth: 03/06/1979 Age/Sex: 37 M

Attending Physician: LITTMAN, MARIO, MD

**risperidONE (risperidONE) 2 Mg Tablet**

2 MG ORAL TWICE A DAY 30 Days

Rx# 0000001019 Days: 30 Refills: 0 TABLET

Entered Date: Nov 1, 2016 Compound Med: No

Ordering Provider: SHETVI Location: FI4PVA

Diagnosis:

**Folic Acid (Folic Acid) 1 Mg Tablet**

1 MG ORAL DAILY 30 Days

Rx# 0000001020 Days: 30 Refills: 0 TABLET

Entered Date: Nov 1, 2016 Compound Med: No

Ordering Provider: SHETVI Location: FI4PVA

Diagnosis:

**Cephalexin (Cephalexin) 500 Mg Capsule**

500 MG ORAL EVERY 8 HOURS 14 Days

Rx# 0000001021 Days: 14 Refills: 0 CAPSULE

Entered Date: Nov 1, 2016 Compound Med: No

Ordering Provider: SHETVI Location: FI4PVA

Diagnosis:

**Latanoprost (Latanoprost) 2.5 Ml Drops**

1 DROP BOTH EYES EVERY EVENING 30 Days

Rx# 0000001023 Days: 30 Refills: 0

Entered Date: Nov 1, 2016 Compound Med: No

Ordering Provider: SHETVI Location: FI4PVA

Diagnosis:

**Clotrimazole (Clotrimazole) 10 Ml Solution**

1 APPLIC TOPICAL 5 TIMES DAILY 30 Days

Rx# 0000001024 Days: 30 Refills: 0 SOLUTION

Entered Date: Nov 1, 2016 Compound Med: No

Ordering Provider: SHETVI Location: FI4PVA

Diagnosis:

**Referrals**

**Internal Medic Ref**

In 14 Days

To Practice:

To Provider:

Referral Authorization Date:

Referral Expiration Date:

Referral Type:

Diagnosis:

# OF VISITS: Active

Sheth, Vishad M Md



DATE: 11/11/16 @ 0049  
USER: MT

Mercy Fitzgerald Hospital AOM \*LIVE\*  
Ambulatory Prescriptions and Procedures

PAGE 3

Patient Name: EFUNNUGA OLUTOKUNBO

Admission/Registration Date: 10/07/16

Unit Number: F001250247

Discharge Date: 11/01/16

Account Number: FA1307223089

Admitting Physican: LITTMAN, MARIO, MD

Date of Birth: 03/06/1979 Age/Sex: 37 M

Attending Physican: LITTMAN, MARIO, MD

**Cardiovasc Surg Ref**

In 28 Days

To Practice:

To Provider: Shariff, Haja M Md

Referral Authorization Date:

Referral Expiration Date:

Referral Type:

Diagnosis:

# OF VISITS: Active

Sheth, Vishad M Md

**Infectious Dis Ref**

In 21 Days

To Practice:

To Provider:

Referral Authorization Date:

Referral Expiration Date:

Referral Type:

Diagnosis:

# OF VISITS: Active

Sheth, Vishad M Md

**Discontinued Prescriptions**

Flagyl (metronIDAZOLE) 500 Mg Tablet

500 MG ORAL TWICE A DAY 7 Days

Rx# 0000001022 Days: 7 Refills: 0 TABLET

Entered Date: Nov 1, 2016 Compound Med: No

Ordering Provider: SHETVI Location: FI4PVA

Diagnosis:

**Discontinued Reported Medications**

Xalatan (Latanoprost) 2.5 Ml Drops

1 DROP BOTH EYES EVERY EVENING

Refills: 0

Date: Oct 7, 2016

DROPS

Instructions: 2.5 ML

Location: FI5ICU

Diagnosis: